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ABSTRACT

The report examines needs and policy implications for serving emotionally disturbed and behavior disordered individuals in South Carolina. The first section focuses on children and adolescents and considers demographic and incidence figures as well as offering a composite profile. Students' problems and needs are identified, including a lack of service coordination and resources and a lack of alternatives and service continuity. Recommendations address coordination of services and a continuum of services. The second section follows the same format for adults. Case profiles are followed by a consideration of problems and needs of institutionalized and community residents. Recommendations for adults include designating a lead agency for working toward establishing a coordinated continuum of services. Appended material includes data analysis and descriptions of model programs. (CL)

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ED268735

FILLING IN THE CRACKS

A Study of the Problems and Needs of Severely Emotionally Handicapped Children and Adolescents and of Mentally Retarded/Emotionally Handicapped Adults in South Carolina, March of 1982

Sponsored by

South Carolina Protection and Advocacy System for the Handicapped

in cooperation with

South Carolina Developmental Disabilities Council
Office of Criminal Justice, Division of Public Safety Programs
South Carolina Joint Legislative Education Finance Review Committee

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INTRODUCTION

Ever since the P&A System in South Carolina opened its doors, the most difficult cases have proven to be those of persons who suffer from severe emotional and/or behavior disorders. What makes these particular cases almost impossible to resolve, and thus, most frustrating to P&A's advocates, is the dearth of resources within the state to adequately meet the needs of this rather sizeable group of individuals. The type and severity of handicap suffered by these individuals, combined with the lack of appropriate services, sadly, leads too many of them into trouble with the law. When they end up incarcerated, it makes matters all the more difficult for all involved.

In September of 1981, the South Carolina Developmental Disabilities Council sponsored the P&A System's efforts to initiate a study to document and analyze actual cases from the files of the P&A System and to also obtain input from key policymakers concerned with these problems.

The project was envisioned to provide needed information and recommendations to support and strengthen joint systems advocacy efforts in this area. It would present a concise, yet comprehensive view of the complex problems and barriers existing in South Carolina in serving this group of individuals who, through no fault of their own, perpetually fall through the "cracks" of the services system and more often than not end up institutionalized or incarcerated at great expense to South Carolina's taxpayers.

Preliminary contacts were established with key policymakers in the State. At least one meeting, lasting two to three hours each, was held with each of these officials and/or their representatives. During the interviews, the needs and problems of this target population were discussed from the vantage point of each of these agencies/groups and their recommendations were elicited regarding resolutions and alternate ways of providing more appropriate services to these individuals. A listing of these policymakers follows.

Dr. Charlest D. Barnett, Commissioner
S. C. Department of Mental Retardation

Dr. William S. Hall, Commissioner
S. C. Department of Mental Health

Dr. Robert S. Black, Director
Office of Programs for the Handicapped
S. C. Department of Education

Mr. Virgil L. Conrad, Commissioner
S. C. Department of Social Services

Mr. J. P. Neal, Jr., Director
S. C. Department of Youth Services

Mr. William D. Leeke, Commissioner
S. C. Department of Corrections

Mr. Harry W. Davis, Jr., Director
S. C. Department of Juvenile Placement and Aftercare

Mr. Ritchie P. Tidwell, Director
Criminal Justice Programs
Office of the Governor

Mr. Gary Patterson, Executive Director
Children's Cabinet
Office of the Governor

Senator Dewey Wise, Chairman
Joint Legislative Committee on Children

Senator Harry A. Chapman, Jr., Chairman
Joint Legislative Education Finance Review Committee

Representative Patrick B. Harris, Chairman
Legislative-Governor's Committee on Mental Health
and Mental Retardation

Senator Heyward E. McDonald, Chairman
Legislative Committee to Study Problems of the
Handicapped

These contacts generated the need to meet with the following additional individuals and groups to solicit valuable input:

*Other key legislators

Alston-Wilkes Society

Charleston County, Richland County, and Lexington County
School District Special Education Administrators

S. C. Association of School Administrators

S. C. School Board Association

Adult and Children Services Division of S. C.
Department of Social Services

John DeLa Howe School

William S. Hall Psychiatric Institute
Children and Adolescent Services

Child and Adolescent Unit at S. C. State Hospital
(Blanding House)

Council of Administrators of Special Education Programs

*Ombudsman, Office of the Governor

S. C. School for the Deaf and the Blind

*Mental Health Association of the Midlands

S. C. Department of Parole and Community Corrections

*Carolina Society for Adolescent Psychiatry

Therapeutic Foster Home Program for Emotionally Disturbed Children

Office of the Governor, Division of Health and and Human Services

Probate Judges Association

A Community Mental Health Center

Families and Friends of the Mentally Ill

*These individuals or groups were informed of the study by letter, but no follow-up was made.

Along with these activites, P&A's total caseload for the period December, 1979 through August, 1981 was undertaken to identify all cases (closed as well as active) of either (1) severely emotionally disturbed children and adolescents or (2) individuals who are both emotionally handicapped and mentally retarded.

Of a total of 1,184 cases, 205 clients, or 17% of P&A's caseload, were identified as falling in these categories.

Criteria	P&A Office	Number of Clients (unduplicated)
1) EH Children & Adolescents	Region I	16
	Region II	29
	Region III	23
	Region IV	16
	Offender Advocate	25
Sub-total		109
2) MR/EH Children & Adolescents	Region I	14
	Region II	15
	Region III	9
	Region IV	6
	Offender Advocate	10
Sub-total		54
3) MR/EH Adults	Region I	5
	Region II	7
	Region III	4
	Region IV	17
	Offender Advocate	9
Sub-total		42

Data Collection instruments were especially designed in order to document, in detail, the problems and needs of this group of P&A clients. Two separate forms were developed and pilot-tested for the purpose of data collection. Because the number of cases identified in the target population ended up to be twice what was originally expected and the fact that a great deal of interest and enthusiasm was exhibited by this study, additional time and effort was required to complete the project.

Fortunately, the project was supported by added funding from both the Division of Public Safety Programs, Office of Criminal Justice in the Office of the Governor and the Joint Legislative Education Finance Review Committee in order to 1) document the remaining cases, 2) aggregate and analyze the data collected, and 3) compile the final report for presentation to the Juvenile Advisory Council, the Children's Coordinating Cabinet and other appropriate legislative committees.

AUTHORS

The following persons, including P&A staff members and consultants, participated directly in the development and completion of the final report of this study. These individuals are listed along with an identification of their primary involvement in the project.

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Identification of Problems and Needs
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Phyllis M. Ross
Typing Manuscript

Hazel P. Mengedoht
Typing Assistance

The authors of this study wish to express their appreciation to the various legislators, agency representatives and individuals for the time they took from their busy schedules, for their sincere concern, openness and candid appraisal of the problems and needs of this population, and the thought and creativity they demonstrated in coming up with viable solutions. Without their help and willingness to participate, this study would not have been possible.

CREDITS

Several essential ingredients are necessary if a project such as this one is to germinate and thrive. The main ingredient is, no doubt, the feeling of concern which an individual, or a group of individuals, brings to the problem and the committment to resolve it.

So it was when the advocates of the P&A System, extremely frustrated over the many problems of emotionally disturbed individuals, refused to give up on their clients. This first credit, then, has been reserved for the advocates of the P&A System, for this study may not have happened except for their persistence and belief that something should be done to help this group of handicapped people.

With the unanimous support of the P&A System's Board of Directors and the impetus of Louise R. Ravenel as P&A's Executive Director, the project was germinated, thanks to the efforts of the Governor's Office and the initial sponsorship and funding of the South Carolina Developmental Disabilities Council. Credit must be given here to Sarah Shuptrine, Director of the Division of Health and Human Services in the Office of the Governor, in appreciation for her interest and committment to such a study.

Well deserved credits are also in order to Ritchie Tidwell, Director of Public Safety Programs at the Office of the Governor and to Joy Sovde, who, as a consultant with the Joint Legislative Education Finance Review Committee, committed themselves to assist and obtain additional funding to sponsor this study.

Final credits for this study cannot be written until its participants emerge and resolve, finally, the serious problems of emotionally handicapped persons in South Carolina.

PART I

CHILDREN AND ADOLESCENTS

WHO ARE THESE CHILDREN?

South Carolina Protection and Advocacy System's
Case Documentation

CASE PROFILES

While it is not possible to gain complete understanding of these children or adolescents without thoroughly reviewing their individual case histories, several sample profiles may help to provide a sense of the range and variety of circumstances and influencing conditions involved.[1]

TED was first diagnosed emotionally handicapped (EH) at age seven; due to his home circumstances involving both physical and sexual abuse, parental rights were terminated when he was eleven. During the next two years, he moved through seven foster care, group residences and pre-adoptive placements, all unsuccessful. Since no other foster care placement was available, he was returned to live with his natural family. Emotional problems and disruptive behavior persist; he now has been charged with a criminal offense.

SIDNEY is thirteen, hyperactive, was diagnosed as EH in the second grade, and has been severely abused by his father for many years. Last year he attended school a total of eight days because of numerous suspensions due to fights, assaults on teachers and other students, throwing books and chairs, cursing, and refusal to obey rules. Outpatient treatment at the mental health center has been intermittent and unsuccessful due to parents' refusal to keep appointments.

DAVID is now fifteen. In the first grade he was depressed and cried a lot, was overactive and aggressive - hitting and kicking other children. Medical evaluations confirmed a "congenital pituitary imbalance". A psychological evaluation noted hyperactivity, psychomotor disability and speech disorders. By the end of second grade, he had made little progress and was significantly lagging in school. In grade three, the hyperactivity increased and he exposed himself and sexually assaulted smaller children. His aggressive sexual behavior was beyond the school's capability. The boy has received outpatient mental health treatment intermittently since age seven, which the Mental Health Center (MHC) now refuses as inappropriate. He has been admitted for inpatient pyschiatric care several times, but each time residential treatment has been recommended, he has been returned home to self-contained EH classes in public school from which he has been expelled for assault and drug abuse. He has been arrested for sexually molesting young children and currently is awaiting trial. School officials claim he can be appropriately served in a public school setting. He has a history of being physically abused.

[1]Names and other pertinent identifying factors have been changed to retain the strictest confidentiality of P&A's clients as documented in this study.

WILLIAM, a teenager, was diagnosed EH in first grade and has been in eight different special education programs; has had five different crisis admissions to Blanding House at the Department of Mental Health (DMH); has been treated with inpatient and outpatient psychiatric services at the Medical University of South Carolina (MUSC) and Hall Institute. He has been "unable to benefit from outpatient treatment" and has been expelled from three residential treatment programs for violence to other children and staff; he has attempted suicide and repeatedly attacked others with weapons. Every evaluation has recommended a long-term residential school for emotionally disturbed, but in every instance, available treatment services in South Carolina have been unable to cope with his violent behavior. The youth has borderline mental retardation, moderate epilepsy and severe learning disability.

RICHARD'S mother deserted him when he was three. At eleven, sometime after being told of his mother's suicide, he was admitted to Blanding suffering hallucinations, bizarre behavior (eating hair, worms, feces), preoccupation with religion and sexual acting out. He was diagnosed psychotic and epileptic and was discharged after nine months. Within a month, he was returned for running away, suicide attempts and injuring another child at school. He was expelled from public school and sent to a group home for nine months. After being returned to his family, he attempted to stab his uncle and a policeman who responded to the call. Richard was then sent to another youth treatment center which he vandalized, then broke into a home and stole a gun, threatening suicide. He returned to Blanding where he slit his wrists and was sent to the Department of Youth Services (DYS) where he is now, at fifteen, diagnosed psychotic, latent schizophrenic and epileptic. A long-term residential mental health treatment placement has been recommended for this child since age twelve, but the school district refuses to fund any out-of-state facility until all South Carolina's resources are exhausted.

PHILLIP was first evaluated in first grade because of hyperactivity and self-abusive behavior. He would slap his face and bite himself when upset. He was placed in Trainable Mentally Handicapped (TMH) and Educable Mentally Handicapped (EMH) classes for retarded children. Re-evaluation at age nine showed borderline mental retardation, but indicated his slow learning was due more to emotional problems than intellectual deficit. By age eleven he had developed serious behavior and self-abuse problems and was sent to a residential treatment program; then returned to public school. Another evaluation showed EH and learning disability (LD). He spent six months in an EH day program then was admitted to Blanding for choking his little sister. He spent six months in a youth development center, but was dismissed for hitting a teacher with a shovel. Outpatient mental health treatment has been continuous since age twelve although a long-term residential treatment school has been recommended. Phillip has a history of being physically abused.

MARK is now teenaged, but as a young child he was physically abused; both his mother and father were alcoholics. At eight, his mother abandoned him because she had remarried and her new husband didn't want him. Since then, there have been numerous suicide attempts: he swallowed acid and overdosed on pills. He has been in two children's homes, five group homes, two emergency shelters, one foster home, and has had numerous incorrigible offenses. Recommendations from every psychiatric evaluation was long-term residential treatment for suicide prevention.

JOSEPH was hospitalized at two years of age for a brain abcess and is moderately retarded and a Grand Mal epileptic. He has speech disorders and possible progressive brain damage. Joseph stabbed a neighbor when refused use of bathroom. He is now thirteen years old.

POLLY is a teenager who is mentally retarded, hyperactive and learning disabled. She was identified as emotionally handicapped by school personnel when she was ten. She has been in more than four foster homes and has had two crisis admissions to Blanding. She is disruptive in school, has run away from home, broken into homes and set fires. Last summer Polly's mother killed her father and was sent to prison. Shortly after that, Polly did $600 worth of damage to her current foster home and as a result was committed to DYS.

BRENDA is in her late teens. She was diagnosed as epileptic and behavior disordered and began psychiatric treatment before age five. Between the ages of twelve and fifteen, she had three crisis admissions for inpatient pyschiatric treatment and five unsuccessful foster home placements. When she was thirteen, her mother abdicated responsibility and she was sent to live with her father. At fifteen, she was placed at a girls' home. Since that time she has been with a volunteer family (four days); in jail (five days); in youth home (one night); run away house (one month); in a second home (two weeks); group home (four months); second run away shelter (two days); DYS R&E youth corrections (one month); third foster home (one week); youth home (one day); detention center (three days); and fourth foster home (two months) awaiting release for adoption. She was adopted by an out-of-state family who three weeks later sought relief of their custody. She was finally committed to one of DYS's corrections facilities on one of her old assault charges and shortly thereafter she attempted suicide. Every placement has failed due to violently assaultive behavior and running away. The status of her legal custody is still questionable.

As these case profiles indicate, not all of these..."children are alike - they vary in age, in size and strength, in types of assaultive and violent behaviors, and in the causative factors that precipitate their violence.

(a) Some of these children have serious mental illness as their primary problem. They are schizophrenic - they perceive the world in a paranoid fashion and strike out in "self-defense" of perceived threats. Depending upon their degree of psychosis, which varies in relation to external and internal stress, they are more violent or less violent, as well as more able or less able to function in "every day society".

(b) A second type of seriously mentally ill child is the severely depressed, suicidal child whose violence is self-directed.

(c) Other...children are neurologically impaired-brain damaged, and...react with violence to situations that are overly stimulating, confusing, noisy and unstructured. Unlike the schizophrenic child, these children are not reacting to perceived threats, but are venting frustrations derived from an inability to cope...to organize their environment.

(d) Yet another type of...child is the self-abusive, unpredictably destructive retarded child.

(e) A fifth type of...child is that child who has none of the limitations listed above, but who has been exposed to so much violence that he responds to any stress by lashing out at others...

(f) ...some...children are in life situations that are so destructive to them, such as an abusive family, that their violence in a strange way, can be considered "appropriate".

(g) To add to the difficulty of defining clearly the... child is the reality that many of these children are multiply impaired and have combinations of the disorders described above. Some of them are depressed and retarded, some are brain damaged and have experienced severe episodes of child abuse, and so on."[2]

Very simply, these are the very same children and adolescents who grow up as severely emotionally disturbed adults.

[2]"Willie M. Update", Characteristics of Children in the Willie M. Class, Division of Mental Health, Mental Retardation and Substance Abuse, North Carolina, November 1981.

COMPOSITE PROFILE

The significant results of SCP&A's case documentation on children and adolescents are summarized below. Details of the findings and data analysis are presented in full in Appendix A at the back of this report.

Of the total group of children and adolescents under 19 years of age, 168 cases were initially identified as emotionally handicapped from SCP&A's 1980-81 case files. Forty-three of these cases were discarded during the study - 12 where the case files did not provide sufficient information to substantitate a diagnosis of a severe emotional handicap and 33 autistic children. It should be noted that the autistic cases were purposely excluded because of the collaborative programs that have been developed during the past several years between the Department of Mental Health and the public schools, as well as the programs at the Department of Mental Retardation, in most part brought about through the efforts of the parents of autistic children.

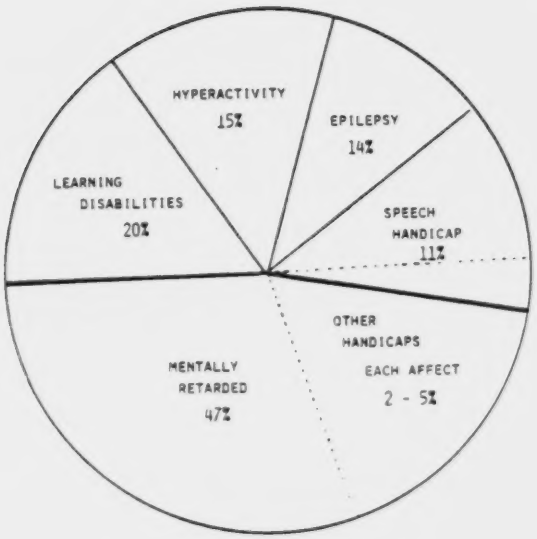
WHAT KINDS OF HANDICAPS WERE FOUND? (See Table II, Appendix A)

One hundred out of the 123 cases examined, or 81.3% of the children in the study, are multiply handicapped. Forty-seven percent of all these children are mentally retarded and 32% have three or more handicaps including their emotional disturbance. The most common handicaps, next to mental retardation, are learning disabilities (20%), epilepsy (14%), and hyperactivity (15%). Sixteen percent have speech and hearing disorders.

Of those in the Offender Advocate's caseload[3], 84% have additional handicaps.

FIGURE 1

HANDICAPS



THESE CHILDREN ARE MULTIPLY HANDICAPPED

81% HAVE ADDITIONAL HANDICAPS BESIDES THEIR EMOTIONAL HANDICAP

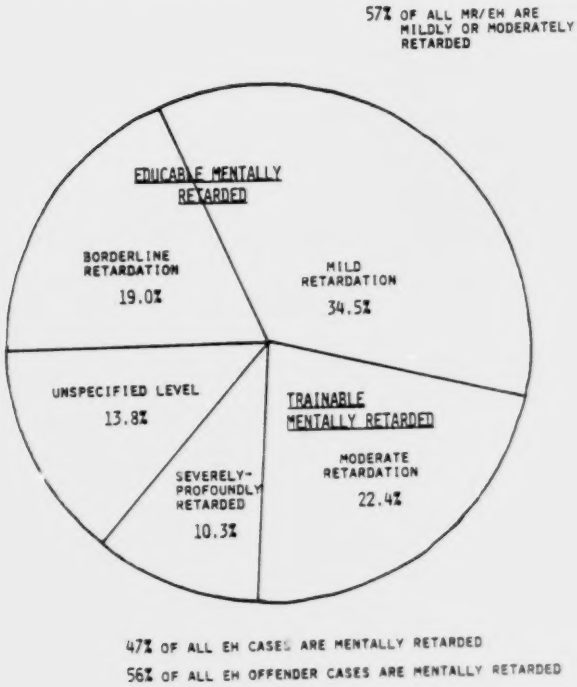
32% HAVE 3 OR MORE HANDICAPS

Of the 58 children diagnosed as retarded, approximately 10% are severely or profoundly retarded, 19% are borderline, 35% are mildly

[3]Offender Advocate: A special project/P&A staff member who works exclusively with handicapped juveniles who get in trouble with the law.

retarded, and 22% are moderately retarded.[4] Although 47% of all these children are retarded, the percentage of retardation evident in the Offender case group is even higher: 56%.

FIGURE 2
LEVELS OF RETARDATION OF MR/EH CHILDREN AND ADOLESCENTS



[4]Definitions/classes of Mental Retardation (IQ's):

South Carolina Department of Mental Retardation

Mild	=	54-68
Moderate	=	36-53
Severe	=	20-35
Profound	=	0-19

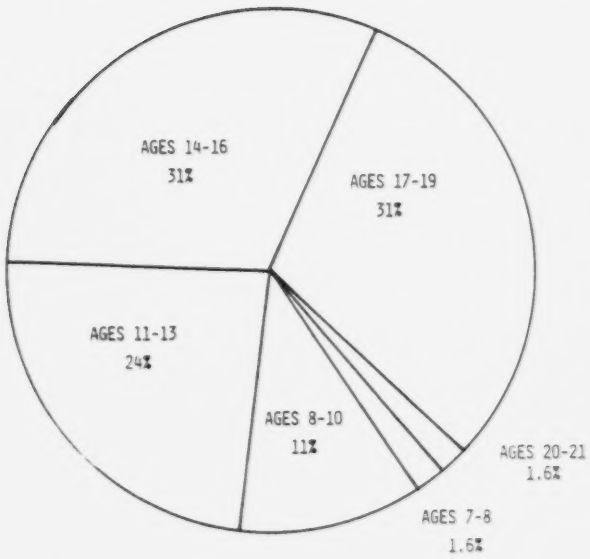
South Carolina Department of Education and School Districts

Educable	=	50-70
Trainable	=	25-50
Profound	=	under 25

DEMOGRAPHIC CHARACTERISTICS (See Tables V - XI, Appendix A)

AGE: These children have an average age of 14.4 years, with 62% being 14-19 and about one-fourth aged 11-13; approximately 13% are 10 and under.

FIGURE 3
AGE



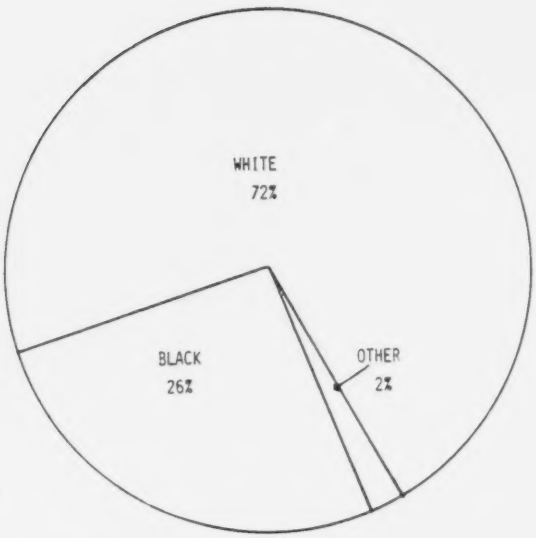
OVER ONE-THIRD OF THESE CHILDREN ARE AGED 13 AND UNDER

THE AVERAGE AGE IS 14.4

RACE/SEX: The children's group is 72% white and 26% black. Seventy three percent are male and 27% are female.

FIGURE 4

RACE

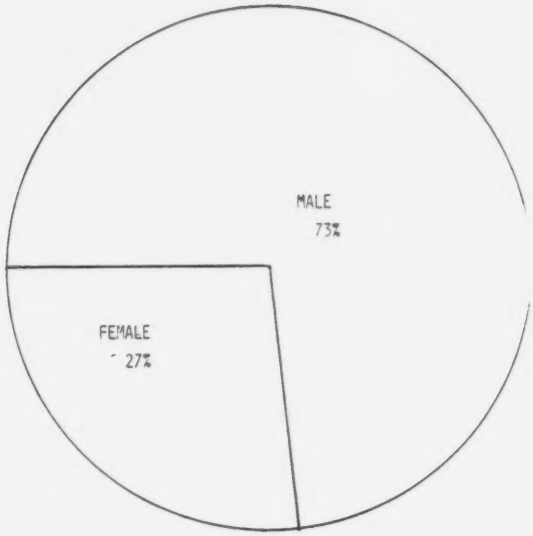


OF THE P&A CASE CHILDREN, OVER /0% ARE WHITE

26% ARE BLACK

FIGURE 5

SEX



THREE-FOURTHS OF THESE CHILDREN AND ADOLESCENTS ARE BOYS

HOME COUNTIES - CURRENT RESIDENCE (See Tables III and IV, Appendix A): Thirty-five of the 46 South Carolina counties are represented in the children's group. These children come from nearly every county in South Carolina, still, over one-third of them do not live in their parent's home. Thirty-five percent of these children are currently residing out of their home county or out-of-state. If the adult group who are 19-21 are added, a total of 36 South Carolina counties are represented.

WHERE ARE THESE CHILDREN LIVING?

At the time of the study these children were physically located in the following settings:

IN THE COMMUNITY			77 (62.6%)
living with natural parents	60	(48.8%)	
living with adoptive parents	6	(4.9%)	
living in foster care	4	(3.3%)	
living with relatives	7	(5.7%)	
IN INSTITUTIONS			43 (35.0%)
in mental health institutions		7 (5.7%)	
Blanding	4		
South Carolina State Hospital	1		
William S. Hall Psychiatric Institute	1		
Medical College of Georgia	1		
in DMR institutions		6 (4.9%)	
Pee Dee	3		
Whitten	1		
Midlands	2		
in DYS institutions		10 (8.1%)	
Willowlane	3		
Birchwood	2		
J. G. Richards	1		
R & E Center	1		
DYS inst. unspecified	3		
in Department of Corrections		1 (.8%)	
Manning			
in temporary emergency shelters		3 (2.4%)	

in residential school/treatment program			16 (13.0%)
In-state -	York Episcopal	2	
	Oak Grove	2	
	Tara Hall	1	
	Fair Play	1	
	Gold Haven	1	
	Springdale	1	
	Opportunity School	1	
	School for the Deaf and Blind	1	
Out-of-state -	Georgia		
	Devereaux	2	
	Brown School	1	
	Florida		
	Ella Mae Chance	1	
	Eckerds Camp	1	
	Montanori	1	
LOCATION UNKNOWN			3 (2.4%)
	TOTAL		123 (100%)

WHO HAS CUSTODY OF THESE CHILDREN? (See Tables XIV - XXVI, Appendix A)

Sixty percent of these children are in the legal custody of their natural parents, but 42% have a history of numerous foster care and group home placements largely in search of an environment that can manage their violent behavior and treat their emotional problems. Nineteen percent are under the custody of DSS, 2% in legal custody of DYS, and 9% are adopted. For 5% of the children, custody is joint between parents and an agency, or in dispute. Forty-two percent of the children have a history of foster care services, and of these, 64% have

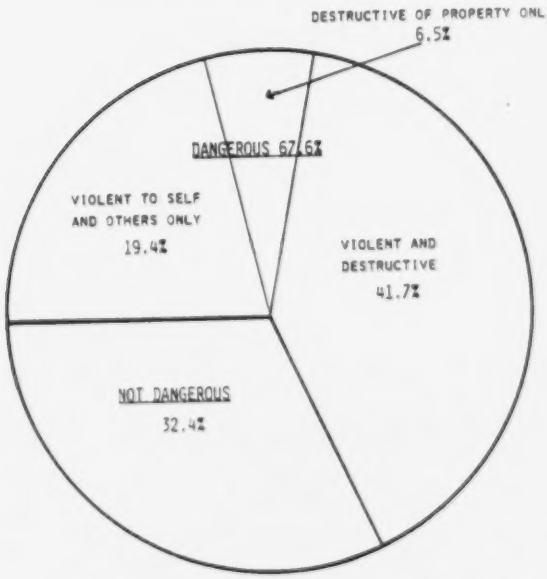
had at least four or more placements; 77% have lived in some type of group residence; and 20% have been in jail. Clearly, these children's lives have been characterized by instability and impermanence, having been shifted from place to place numerous times.

HOW DANGEROUS ARE THESE CHILDREN? (See Tables XII - XIII, Appendix A)

Over two-thirds of the children, or 67.6%, have histories of dangerous behavior, behavior that is violent either to themselves or other persons, destructive of property or both.

FIGURE 6

HOW DANGEROUS ARE THESE CHILDREN?



TWO-THIRDS OF THESE CHILDREN HAVE HISTORIES OF VIOLENT AND DESTRUCTIVE BEHAVIOR; 96% OF OFFENDER CASES HAVE VIOLENT AND DESTRUCTIVE HISTORIES.

OVER HALF OF ALL CHILDREN WERE JUDGED AT RISK FOR CORRECTIONAL PLACEMENT. (56.1%); AND 94% OF OFFENDER CASES.

Well over half of this group was judged at risk for correctional placement, as were 94% of the Offender cases. All but one of the Offender case children have violent and destructive behavior histories.

HAVE THESE CHILDREN BEEN ABUSED?

About one-third of these children also have known histories of physical and/or sexual abuse. Information on abuse is often unavailable to P&A advocates and therefore these percentages are probably low. The EH child is twice as likely to have been abused than the retarded child and about 60% of the Offender case children have abuse histories. Physical abuse predominated, but 41% of the cases involved sexual abuse as well, of both boys and girls, which emphasizes the extreme vulnerability of these children.

ARE THESE CHILDREN UNSERVED OR BEING INAPPROPRIATELY SERVED?

(See Tables XIX - XXII, Appendix A)

Of the 123 cases examined, 41 children, well over one-third (38.5%) were judged unserved or being inappropriately served. Mentally retarded children were more likely to be served inappropriately and 75% of the Offender Advocate's caseload was considered inappropriately served. Most commonly, long-term residential treatment has been recommended to meet their needs, but no program is available or affordable to them.

Eighty-eight percent of these children were multi-handicapped, more likely to have experienced foster care, more than twice as likely to have a history of abuse, and nearly all are considered dangerous.

On the average, the unserved or inappropriately served cases were first identified as emotionally handicapped at 7.4 years of age. All of these unserved children had been identified by the time they were 11 years old. Since their current average age is 14.6 it means that these children have been in the service system in some way for an average of 7 years!

The following lists the service programs that have dealt with these 41 children:

	No. of Children	Percent
Department of Social Services	22	52%
Department of Mental Health[5]	33	79%
Department of Youth Services	20	47%
Department of Mental Retardation	16	38%
Developmental Disabilities Case Coordination	10	24%

As one can readily see, these unserved or inappropriately served children have received services from a number of different programs and/or agencies:

- 19 have used DMH inpatient treatment a total of 59 times for an average of 2.9 admissions
- and have used 27 of the 36 know group residential facilities in the state including youth homes, emergency shelters and the two EH treatment facilities in the state: Oak Grove and York Episcopal Home
- 14 have been suspended from school numerous times
- 10 have been expelled at least once and 3 have been expelled numerous times

[5]Includes the community mental health centers.

- 4 were known not to have an Individualized Education Plan (IEP) and for 10 others existence of an IEP was not known; for one EH-only child, the school district refused to do an IEP
- only 4 had had a due process hearing
- 10 had been evaluated by DMR
- 4 were in the limbo of conflict over which agency had primary responsibility (i.e., DMR saying DMH; DMH saying DMR; etc.).

In summary, the typical child in this study is very likely to be a white male about fourteen years old, with multiple handicaps and a history of abuse. He has had four or more foster care or group residential placements and is exhibiting violent and destructive behavior to the point that he has encountered the juvenile justice system. It is very likely that he is inappropriately served, with the services or treatments recommended not having been implemented. The most frequent recommendation (64%) for this typical child was placement in a long-term residential treatment school program for the emotionally disturbed---but, there is no such program in South Carolina.

WHAT ARE THEIR PROBLEMS AND NEEDS?

Problems and Needs Identification

It is evident that the South Carolina agencies, organizations and individuals interviewed for this study are making sincere and dedicated efforts to serve severely emotionally disturbed children, youth and adults. Their input, however, confirms that the approximately 200 to 800 children[6] affected by this handicap constitute the single, most critical problem and source of frustration among all the agencies and organizations serving children in our state. The impact of their behavior poses a particular problem for education, mental health, social welfare, juvenile justice as well as the advocacy system, and far belies their number as efforts to meet their special needs consume disproportionate amounts of time, money and relentless concern.

It is also apparent that the services and resources available and, more importantly, the manner in which these resources are organized and delivered are inadequate to the task. This inadequacy results in one of several typical scenarios which are detrimental to these children.

The first scenario involves children being shifted from one program to another in a search for suitable, effective treatment. Most of these children are first identified as emotionally handicapped (EH) at an

[6]Estimation of the total number of these children in South Carolina ranges from 200 to 800. SCP&A cases document 123, however, these are the cases which have been brought to the advocates' attention in the last year and a half. However, the Department of Education reports a total of 6,400 EH children being served by schools (1980-81). In a recent Joint Legislative Education Finance Review Committee survey, schools reported 24.1% severe EH children (1,542) and 6.3% of all EH children that cannot be served in a school setting. These figures would meant that approximately 400 children would fall in this unable-to-be-served category.

early age. The movement from foster home to group residence to crisis intervention to emergency shelter to foster home has serious detrimental effects on the fragile emotional status of the EH child, often resulting in mild emotional handicaps becoming severe emotional disorders. If the cost of this continued service search were aggregated, (which was beyond the scope of this study) it could conceivably total more than the cost of appropriate treatment.

A second typical scenario is that of children being treated inappropriately or not being treated at all. Inappropriate services for children seems to result primarily from services delayed, that is, needs have been identified, but because of lack of funds or lack of suitable in-state programs, the child is left waiting for an appropriate placement. In a few cases, children are being sent out-of-state for residential school treatment at extremely high cost to taxpayers and to families. More often, however, school districts, social services and families do not have the funds to assume such costs resulting in inappropriate placements and treatment and the continuance of the "services search".

In yet a third fairly typical situation, the inability to resolve the problems of these children results in a high level of frustration on the part of parents, school, mental health and mental retardation personnel, ultimately leading to professional "burn out" from trying to deal with the disruptive and often dangerous behavior of these youngsters without the appropriate treatment services or settings. When professionals and parents give up on these children, committment to the Department of Youth Services is usually used as the last resort.

INABILITY TO DEAL WITH VIOLENT BEHAVIOR

Central to all of these scenarios is the inability of parents and local community agencies, i.e., schools and community mental health centers (CMHC) to effectively handle children who periodically and unexpectedly explode in violent and destructive behavior. Schools are particularly unable to handle the violent and destructive child in available EH classrooms. They are concerned for the safety of other children and teachers, uncertain about the extent of their legal liability if someone is hurt, and lack a "back-up" secure facility immediately available in which the violent child can be restrained until the crisis is over.

Maintaining these children in school-based programs causes critical concern to school personnel since the severely emotionally disturbed are often dangerous to self or others. They bring weapons such as knives, brass knuckles, scissors, "knumb chucks", loaded revolvers to school, will physically assault the teachers and other students, and sometimes threaten to kill themselves, teachers, or other students. They are physically and verbally abusive, break windows and school furniture, provoke fights with others, make inappropriate sexual advances, run-away from school; others inflict self-harm to themselves such as biting, hitting, head banging, etc.

When an unexpected crisis situation arises school personnel are also uncertain about their legal and financial obligation for provision of mental health services. For example, in Charleston County schools last year, approximately 35 severely emotionally disturbed children and

adolescents were served in an educational program, yet did not receive adequate services such as psychotherapy, family counseling, or in some cases, the needed residential mental health treatment school program. "Related services" are mandated under PL 94-142, for most if not all of these services, but the fact is that local school districts do not receive sufficient federal, state, and local funds to purchase an adequate amount of these services. This is particularly true in cases of children who need a highly-structured, 24-hour a day, long-term treatment/school program but for whom there is no such facility in South Carolina. Since out-of-state placements of this type are currently costing anywhere from $20,000 to $40,000 per year, it is no small wonder that the schools are reluctant to recommend such placements even though they realize that for these children it may be the only appropriate option. On the other hand, there are some of these children and adolescents who school district personnel feel can be adequately served at the local school setting on a 6-hour per day basis but who, nontheless, demand a residential alternative due to problems their behaviors present at home.

Unfortunately, the local districts do not have the money to provide all of the necessary services. To deal with this, they have chosen to write IEP's for handicapped children on the basis of the services the districts can provide, not on the basis of what these children actually need. School districts do not want to admit that they cannot provide an appropriate education for children who need residential school services because they will be liable under PL 94-142 to pay for an out-of-state placement. The districts are admittedly afraid of the consequences ---

the main reason why it is so difficult to get accurate figures on the extent of this particular problem.[7]

While crisis intervention services are centrally available through DMH, i.e., Blanding Program, it takes considerable time and delay for a child to be admitted and the length of stay is short-term, that is, only until the child's psychotic reactions are stabilized. The child is then returned to the home/school environment which lacked the capacity to effectively deal with his/her behavioral problems in the first place.

Parents, school and other professionals become extremely frustrated by this occurrence and these frustrations tend to arise from differing expectations of the effectiveness of mental health services. Parents and school personnel particularly seem to expect the child to return to them in a manageable state. In some instances, there are differing opinions between mental health professionals and the courts as to how quickly these children should be released. DMH treatment may be able to stabilize the child and control his/her psychotic behaviors, but the short-term in-patient treatment they can currently provide is not sufficient or capable of ameliorating the long-term behavior problems.

[7]The Joint Legislative Education Finance Review Committee is currently conducting a special study with regards to emotionally handicapped children, and hopefully, this will provide more adequate information to substantiate the extent of this very serious problem.

As stated above, presently there is no suitable facility in the state for the violent child who requires intermediate or long-term residential treatment to ameliorate the behavior problem as well as continue their educational services. Nearly every agency and individual interviewed for this study stressed the critical need for a long-term residential mental health treatment facility which includes school services for severely emotionally disturbed children whose behavior is violent and destructive.[8]

LACK OF SERVICE COORDINATION AND RESOURCES

These children "fall through the cracks" in the present service system largely because there is little continuity in the system. In a few communities, a means of coordinating children's services has been attempted locally, but continuity and a coordinated approach to handling these children is not a uniform aspect of the statewide system. No one person or agency is responsible for monitoring a child's case to assure delivery of the services needed. This is particularly true when a child returns to home-base after crisis intervention services.[9] Schools and

[8]Discussions and interagency planning is currently going on among key representatives of John De La Howe School, DSS, DYS, DMH, School for the Deaf and Blind and the Department of Education as to the feasibility of developing a residential treatment school program at the John De La Howe School.

[9]Mental health professionals pointed out the problem of continuity of care after discharge from crisis intervention service in terms of the inability to deal with parental refusal to participate in the treatment program. The feeling was, "We can fix the child, but we can't fix the home."

parents also seem isolated from the flow of communication about the child; this isolation points up the lack of interagency communication at the local level.

Because of the extreme frustration in dealing with these clients, most agency personnel expressed their criticism over the lack of cooperation and communication of other agencies in joint staffings and in providing related services needed for these clients. As an example, there is substantial concern and confusion reported by education, youth services, and mental health staff regarding delivery of mental health services by the community mental health centers. There is concern over cost,[10] availability of specialized child and adolescent services, and the capacity of community mental health centers to follow-up and obtain medication compliance for their clients. Frustration was also evident over the reality that DMH can provide long-term treatment for mentally impaired adults, but not for severe EH children, and in the perception that some mental health facilities, i.e. William S. Hall Psychiatric Institute and community mental health centers (CMHC) can be selective in their provision of treatment services while schools and juvenile justice agencies cannot. While some who were interviewed expressed difficulties,

[10]Another problem frequently mentioned by several agencies is the cost of CMHC services. It was felt that DMH, as a state agency, should not be charging other state agencies, such as the Department of Youth Services and the Department of Education, for services. Also, DYS's community programs presently purchase mental health services from the private sector in some communites because they are less expensive than contracting with CMHC's.

others and particularly several of the community mental retardation programs, noted the extreme cooperation and assistance of some CHMC's in providing on-site mental health services, staff development and cooperative programming. One school district has reported the full cooperation of the local mental health center staff who provided exemplary assistance in attempting to procure appropriate services for a child.

The discrepancy of perceptions seemed to be a function of personality and the type of interagency relationships developed at the local level, which provides further evidence of the shortcomings of and lack of uniformity in the present non-system and the need for cooperative interagency case management of these individuals. Schools, mental health personnel and DYS particularly note the decreasing capacity of community mental health centers to provide children and adolescent services. Funding cutbacks and the reduction in community mental health center's mandated services have resulted in the threatened loss of what few children and adolescent specialists are presently available, a loss which would force children to have to compete with adults for service priority.

Neighboring states, by comparison, are putting a greater percentage of their mental health dollars into community services. South Carolina is presently spending $6.70 per capita on community mental health, whereas Georgia spends $10.20 and North Carolina, $16.20. The rate of reduction of psychiatric hospital resident population has been much slower in South Carolina. The per capita rate for these hospitals' average daily census is 10.4 per 10,000 in this state whereas rates for

Georgia and North Carolina are 5.2 and 5.5, respectively.[11]

In 1980 the Subcommittee on Mental Health Problems of Children and Adolescents and the Subcommittee to Study Emergency Mental Health Services, both of the Joint Legislative Committee on Mental Health and Mental Retardation, adopted a Resolution which recommended that all of DMH's Patient Fee Account monies, other than for capital improvements, be used exclusively by DMH to finance community mental health programs. Despite the strong feelings expressed by the members, this did not occur (see full text of their findings in Appendix B). What actually happened during the 1981-82 fiscal year was that a total of $3.8 million has been transferred from the Patient Fee Account at DMH over to the state's General Fund (unspecified). During this same period, an additional $3.7 million was also drawn from this account of which $1.3 million was earmarked for institutional care and less than $2.4 million for community mental health programs. More recently, the Budget and Control Board has again recommended to the members of the Legislature that in Fiscal Year 1982-83 another $3.8 million also be taken from DMH's Patient Fee Account and placed in the General Fund.

[11]"The Mentally Retarded and Mentally Ill Citizen: A Report to the South Carolina General Assembly", South Carolina Departments of Mental Health and Mental Retardation, December 1981.

This report goes on to say: "The implication of the foregoing is that a major key to further deinstitutionalization is the development and strengthening of specific resources based in the community. Any significant change requires significant community resource development."

Although a number of key policymakers and agency officials have placed high priority on the need to strengthen mental health services for children and adolescents in the community, increased funding for these programs has never started flowing.

Still another near-universal problem area was that of records transfer and confidentiality of records. Records transfers are slow, if they occur at all, between agencies due to perceived confidentiality problems. This results in delayed placements and in professionals not having all the information on a child available to them in making crucial placement decisions. There were even problems cited by education professionals with intragency transfers of records.

LACK OF ALTERNATIVES AND SERVICE CONTINUITY

In addition to the problems presented by the lack of coordination of services, there is also a lack of alternative types of services which will permit progressive re-entry of these children and adolescents to a normal environment. Already noted and most conspiciously lacking in the eyes of the agencies interviewed is a long-term residential treatment facility with a school component.

South Carolina has some short-term confinement capabilities (crisis intervention), correctional confinement and normal school environments that may be able to effectively handle some EH children. However, there are no intermediate steps for the child needing close supervision and long-term treatment, or alternative home/school programs, capable of providing structured living, developmental training, mental health and educational skills. The foster care and group home environments currently

available lack the treatment capability to deal with the severely emotionally disturbed (violent and destructive) child. When a child in foster care or group home has an episode, he is returned to DSS or the parent and school district who is then forced to go searching for another placement. Support and back-up services to parents, foster parents, house parents, and schools assuming responsibility for dangerous children are also urgently needed but virtually unavailable within the state.

Furthermore, the lack of these intermediate components of the necessary continuum of services contributes to the overcrowding and overuse of the components which are available. The Department of Mental Health reported overflow figures in a memo to its Child and Youth Council. This overflow results in approximately six to ten adolescents per year being placed in adult units at the State Hospital for periods of several days. The Department of Youth Services also reports that its facilities are extremely overcrowded; one facility, John G. Richards, is presently 80% over maximum capacity.

When crises arise, these children usually end up in Family Court on a Delinquency Petition or Probate Court on a Committment Petition. The judges are compelled to make use of the services available, whether totally appropriate or not, in order to provide the children with, at a minimum, a safe, secure place to stay. If these children are later determined to be inappropriate for Blanding by their professional staff, they are often recommended to correctional facilities or are discharged back into the same crisis-provoking situation as before, and eventually come back before the court again for another committment. This is what is referred to as the "Revolving Door Phenomenon".

Committing these children to Youth Services merely adds to the overcrowding of those institutions and does nothing to meet the child's treatment needs, as DYS has a very limited mental health treatment program of its own.

In summary, the problems experienced by these children and adolescents can be identified as

- inability to educationally serve the violent child in the school setting due to risks to safety to others and uncertainity about school liability, costs
- difficulty in obtaining community mental health treatment for the emotionally handicapped child and his/her family due to insufficient resources to provide consistent, on-going mental health services available to these children
- lack of cooperative case management of severe emotionally handicapped children by all service agencies involved
- difficulties in records transfers and records problems due to confidentiality restrictions
- lack of a range of treatment alternatives, or continuum of services, that would allow for smoother entry and/or re-entry from highly-structured secure facilities to more normalized environments that fit the individual child's needs.

It was extremely apparent from both P&A's case documentation as well as the agency interviews, that although the actual number of these children is not that large, they constitute a major portion of the children's service delivery problem in South Carolina and are at the root of much of the frustration with and critcism of South Carolina's service agencies.

HOW CAN WE SOLVE THEIR PROBLEMS?

Recommendations

The agency personnel and other individuals interviewed for this study were unanimous in their recognition of the problems and frustrations involved in providing services needed by this group of children. They were also unanimous in their agreement of the types of services needed. These are the children that perpetually "fall through the cracks" in South Carolina because

1. No one agency has the clout to coordinate multi-disciplinary services needed by these children or to assure that needed services and funds are indeed provided;

2. current processes and procedures for moving children from one type of service to another are ineffective and uncoordinated and contribute to increasing the child's instability and severity of his/her emotional disorder;

3. a range of treatment alternatives including therapeutic foster care is insufficiently available; and

4. appropriate intermediate and long-term residential mental health treatment with supportive special education services is virtually non-existent.

The striking similarity of North and South Carolina' experiences with these children should be pointed out. In 1980 a similar study was conducted in North Carolina. This study, The Dirty, Rotten Kid Study, identified what is now termed the "Willie M. Class" of children -- severely emotionally disturbed, violent children who could find no appropriate treatment in the North Carolina service system. The cases of children examined in this P&A study undeniably fit the characteristics of "Willie M." children.

Action for these children in North Carolina was precipitated by the filing of a class action law suit against the state on behalf of these children. Eligibility for membership in the "Willie M. Class" was defined as:

> Those children who are under the age of eighteen and who
>
> 1. are seriously emotionally, neurologically or mentally handicapped; and
>
> 2. whose disorders are accompanied by violent or assaultive behavior; and
>
> 3. who are not receiving appropriate treatment or education; and
>
> 4. who are: (a) now involuntarily institutionalized or involuntarily placed in residential facilities[12], or
>
> (b) whose condition requires such involuntary institutionalization or placement.

RECOMMENDATION ONE: SOUTH CAROLINA SHOULD TAKE IMMEDIATE ACTION TO ESTABLISH THE COORDINATED CONTINUUM OF SERVICES NEEDED BY THESE CHILDREN.

Throughout the course of conducting this study, it was noted that interest has been expressed in various parts of the state toward pursuing legal avenues of relief for these children, but South Carolina should NOT WAIT FOR COURT ACTION TO ARISE ON BEHALF OF THESE CHILDREN.

[12] In North Carolina, all children admitted to treatment programs/facilities are considered to be involuntary clients as they do not volunteer themselves, but are admitted under the advice of parents, guardians or under court committment.

COORDINATION OF SERVICES

Administration

At present, no one agency in South Carolina has responsibility for planning and managing provision of services to these children.[13] But, it is apparent from the problems identified that RESPONSIBILITY FOR THESE CHILDREN MUST BE DESIGNATED. Because of South Carolina's fragmented service delivery system and lack of experience in interagency coordination at the local level, this is a critical question.

A major barrier that must first be overcome is South Carolina's long-term propensity of institutionalizing its deviant populations. South Carolina has one of the nation's highest rates of institutionalization for its mentally retarded, mentally ill and offender populations. Its institutions have been traditionally operated at the state level with almost no obligation to coordinate services with other agencies. This tradition has stifled the development of community-based programs and has more than likely impeded the development

[13]Under PL 94-142 the State Education Agency is legally designated and mandated to assure that each and every handicapped child in the state receives a free and appropriate educational program including "related services". This does not necessarily mean that the Department of Education must directly provide the needed array of services for these children, but simply, that they are responsible to see that they are provided. Unfortunately, this issue has raised such controversy that it remains unresolved, to the detriment of handicapped children, despite considerable efforts on the part of the Legislature, state agency and education officials.

of interagency organization at the local levels. Sadly, South Carolina's progress toward a more positive, local community approach to services has lagged far behind even our neighboring states. This situation cannot be rectified until the state makes a committment to re-order its priorities.

In North Carolina, one agency[14] has assumed full responsibility for administration and coordination of treatment services for this group of children and adolescents. In other states, an interagency organization structure is used. It is recommended that the North Carolina program be examined carefully and ASPECTS OF IT THAT ARE CONSISTENT WITH SOUTH CAROLINA'S CIRCUMSTANCES SHOULD BE INCORPORATED.

It is critical, also, to include all of the state agencies which deal with these children, i.e., DMH, DMR, DYS, DSS, etc., in planning and development activities so that the schools, particularly, do not operate in isolation and all can benefit from their respective expertise. Although the NETS proposal[15] has been nixed, the Department of Education next fiscal year will be providing grants for seed money to school districts interested in developing a consortium

[14]North Carolina's program is developed on a regional/zone basis with the Community Mental Health Board assigned the responsibility of planning and implementing the service delivery system.

[15]Network of Educational Treatment and Services: A proposal considered by the Joint Education Finance Review Committee.

project to provide services to low-incidence handicapped children, including those who are severely emotionally disturbed. This offers an ideal opportunity for new initiatives in coordinated planning, but only if all agencies are involved in the development of the service plan.

Financing

Since financial resources are becoming increasingly limited, there is significant danger that these children will continue to be a major source of frustration and difficulty unless efforts are made to act on their early identification and provide and coordinate the appropriate continuum of treatment services with procedures that facilitate ready access and easy flow-through from one component of treatment to another.

The Joint Education Finance Review Committee has recommended that the Education Finance Bill weightings used to determine the flow of funds for services to the handicapped be increased to provide higher weightings for those low-incidence, severely handicapped children needing more extensive services in the local school districts. This would relieve, somewhat, the considerable added expense of educating severely handicapped children.

Serious consideration should also be given to ESTABLISHING A MORE EQUITABLE BASIS, OR FORMULA, OF FINANCING RESIDENTIAL SCHOOL PLACEMENT OF THESE CHILDREN, thereby decreasing the unfair burden which has

previously been placed on local school districts. At present, the State Department of Education shares half of the cost while the local districts pay for the other fifty percent.

A cost-sharing approach would appear to be the most sensible and fairest solution, with the state picking up a portion of the total cost. The Children's Coordinating Cabinet established by Governor Riley, has recently recognized the problems of emotionally disturbed children and adolescents as a top priority, offering promise toward resolving this issue and other related problems.

CONTINUUM OF SERVICES

Service Delivery System

The thrust of this recommendation is that there is a DIRE NEED FOR A FULL CONTINUUM OF SERVICES FOR THESE CHILDREN -- in a community or regional system -- from the most highly-structured residential facility through community support services which are closely coordinated and integrated in the mainstream of public schools and community life. Many of the components of such a service system are already present in South Carolina -- now -- but cooperation and coordination is needed in order for them to be utilized to much better advantage.

At a minimum, SEVERAL ESSENTIAL PROGRAM COMPONENTS MUST BE DEVELOPED OR EXPANDED in South Carolina such as

1. Therapeutic Foster Care similar to the current pilot program funded by DSS in cooperation with DMH. Appropriate recruitment, selection, training and ongoing support of foster families must include parent groups and mental health professional staff support.

2. Residential Treatment School Program to provide intermediate or long-term mental health treatment together with educational services. Current discussions regarding use of the John De La Howe facility to provide this type of program should be diligently pursued since children could be easily moved on campus to a less restrictive environment when ready.

3. Additional components needed in the continuum of services include community treatment homes similar to the one recently opened in South Greenville, specialized mental health services for institutionalized juvenile offenders at DYS, respite care to provide temporary relief, and out-reach workers to support families in crisis, etc.

Although P&A is not necessarily endorsing any one system as the only one which will work, South Carolina agencies serving these children should SEIZE THE OPPORTUNITY TO LEARN AND BENEFIT FROM THE NORTH CAROLINA EXPERIENCE. North Carolina officials or any other state whose programs seem applicable should certainly be brought in to explain their program model and act as consultants to planning and development of South Carolina's program so we don't have to reinvent the wheel. Such consultation may need to include visitation of the program components in North Carolina. (See draft of programs in North Carolina in Appendix C).

RECOMMENDATION TWO: SOUTH CAROLINA SHOULD REFRAIN FROM APPROVING ANY NEW CAPITAL EXPENDITURES UNTIL THE ISSUE OF THE CONTINUUM OF SERVICES NEEDED BY THESE CHILDREN HAS BEEN RESOLVED.

In his opening remarks before the Budget and Control Board this past fall, Governor Riley stated:

> Every penny we spend on debt service is a penny less we have to spend on better quality services for the people of our state. It is very much ill-advised to continue programs of capital expansion while we are struggling with potential program reductions in agency budgets. I intend to question agency leaders about their capital expansion plans during these hearings, and suggest that the Board seriously consider freezing the issuance of any further bonds for the remainder of this (calendar/fiscal) year.

These remarks are well taken, particularly in light of the findings of this study.

In this period of severe economic hardships it is even more critical that we heed Governor Riley's advice and set aside our precious resources for developing this CONTINUUM OF SERVICES. Unless we do, there is no doubt that most of these youngsters will end up in our prisons or institutions costing the citizens of South Carolina even more, not only in terms of our tax dollars but also in terms of the human resources that we could have salvaged.

PART II

ADULTS

WHO ARE THESE ADULTS?

South Carolina Protection and Advocacy System's
Case Documentation

CASE PROFILES

The second part of this report portrays the status and circumstances of 43 mentally retarded/emotionally handicapped (MR/EH) adults from SCP&A's case documentation.

Since nearly half of the emotionally handicapped children and adolescents examined for purposes of this study were also found to be mentally retarded, the information below presents a glimpse into the future of what is likely to happen to a substantial number of these youth in South Carolina. The following case profiles describe a sampling of this over 19 year old group of individuals.[16]

FRANCES is twenty-three, moderately retarded; her mental illness has included schizophrenia (for which she is on medication), paranoia, hallucinations and violent behavior. Her mother sought an out-of-home placement for her when her aggressive behavior became uncontrollable. She was expelled from a school program and was unable to continue in a DMR adult activity program because of violent behavior. She had several emergency admissions to the State Hospital, but was each time returned home after the initial observation period, with the comment: "not mentally ill, just retarded with behavior problems". Her mother has unsuccessfully continued to seek community placement. Because no bed was available in DMR' facilities, Frances has since been re-admitted to the State Hospital.

STANLEY, twenty-one, has borderline retardation. He began having school problems at age ten, physically attacking other children. He committed murder at age eleven and was sent to a DMH facility. He is paranoid and attacks others under the delusion that they will attack him. He was later moved to DMR by court order. DMR believes Stanley is inappropriately placed since they are unable to provide the intensive mental health treatment he needs.

[16]Names and other pertinent identifying factors have been changed to retain the strictest confidentiality of P&A's clients as documented in this study.

GEORGE is forty years old, moderately retarded and culturally deprived. He never attended school. After being in prison for 10 years, he was paroled and returned home to live with his aging parents, but he violated parole 3 weeks later and was returned to prison, where he remained for 2 more years. George was then placed in the VR center at DMR's Midlands Center, but was discharged as he was "uncooperative". He then stayed in a detention center for 4-5 months until a community residence was located with a VR day program; this placement lasted barely a month. George is back in prison again.

MICHAEL is nineteen years old; he has been receiving mental health treatment since he was eight. He is hyperactive, retarded and had been in special education classes since first grade. He dropped out of school at seventeen, was evaluated by DVR, but was turned down because he was regarded as unemployable. He was then evaluated by DMR, but reportedly had too high an IQ for DMR's service system. His behavior has become more and more unmanageable; he is hostile, combative, throws furniture and has tried to stab one of his parents. He is self-abusive, has auditory hallucinations and abuses alcohol and drugs. Michael has had two emergency admissions to DMH. Although a residential treatment program has been recommended by all agencies involved, there has been no success in finding a program that will take him. He is currently "sitting" at home.

SAM, a thirty-four year old man, is currently institutionalized in a DMR facility. His retardation is borderline to mild, but his emotional problems -- depression, obsessive compulsive tendencies, anxiety and instability -- prevent him from making any progress toward deinstitutionalization. He claims he wants to get out of the institution where his parents placed him when they could no longer tolerate his irresponsible, unstable behavior. A retarded brother lives at home and holds a job. Sam needs a place to live with a higher functioning peer group and a structured work environment with appropriate mental health services, but none has been found.

RALPH is twenty-two years old, moderately retarded and had been institutionalized at a DMR facility. He was released to his family but shortly thereafter had several admissions to the State Hospital following episodes of wandering, incoherence, and running away from home. Discharge planning following each of Ralph's confinements has been incomplete with no family counseling or follow-up. He received no programming and was arrested following a purse snatching incident. DVR services were offered, but his family didn't feel it would help him and were unwilling to urge Ralph to attend. He's still at high risk for getting into trouble with the law.

THOMAS is twenty, with mild retardation, seizure disorders and speech problems. He is uncontrollable at home, violent, steals and sets fires. He stole a car and was charged with grand larceny. The court ordered a psychiatric evaluation. He was found incompetent to stand trial and was diagnosed as psychotic, complicated by drug abuse. Thomas was released from jail when DVR agreed to accept him for day services, but he wouldn't keep his appointments at the vocational rehabilitation center. Why? First, because neither Thomas nor his parents can read and they couldn't understand the appointment notices that the VR counselor sent by mail. Further efforts by DVR to get him in the program failed.

DONALD is twenty and mildly retarded; he was first diagnosed EH at age nine. He was physically abused as a child and has been in numerous shelters and group homes. He has been diagnosed as schizophrenic and has had numerous criminal offenses: indecent exposure, auto theft, sexual assault on his mother. He even burned down his family's home. He has been admitted to the State Hospital for long-term psychiatric care, but his mental retardation needs are still not being met.

HENRY is twenty and now living at home. He is mildly retarded and was identified as emotionally handicapped in elementary school where he was enrolled in special education classes. Because of charges of stealing and breaking and entering, he was referred to DYS's community services. Subsequently, his acting-out behavior resulted in expulsion from VR services. Evaluation by a local mental health center indicated evidence of psychoses or severe emotional handicap. A structured mental retardation residential program was recommended, but no space was available to him at the time. Charges were eventually dropped and a return to EMH classes at the local school district was recommended, but Henry himself said he didn't want to attend and his family refused to make him go. Because he still doesn't have the needed structured program, he will more than likely get in trouble with the law again.

KEVIN is in his early thirties. He is moderately retarded combined with a severe mental disorder and epilepsy. He was admitted to a DMH facility when he was eighteen for uncontrolled aggressive behavior. DMH admits that because they do not have the trained staff to deal with his mental retardation problems, little progress has been made in his psychiatric therapy program. He had been previously served by DMR, first in a community day program, then in one of their residential programs, but the staff was unable to deal with Kevin's volatile behavior. Because there was no other alternative for him, he ended up at the State Hospital. Kevin's parents continue to crusade for more appropriate services.

As with the children and adolescents group in this study, it is important to recognize that not all of these adults are alike. They differ in age, in the degree of their mental and/or emotional handicap, in the disruptive or violent behavior which they exhibit and the factors that trigger such behavior.

As one professional put it

THESE PEOPLE ARE VIOLENT

1% OF THE TIME

BUT THEY ARE HURTING INSIDE

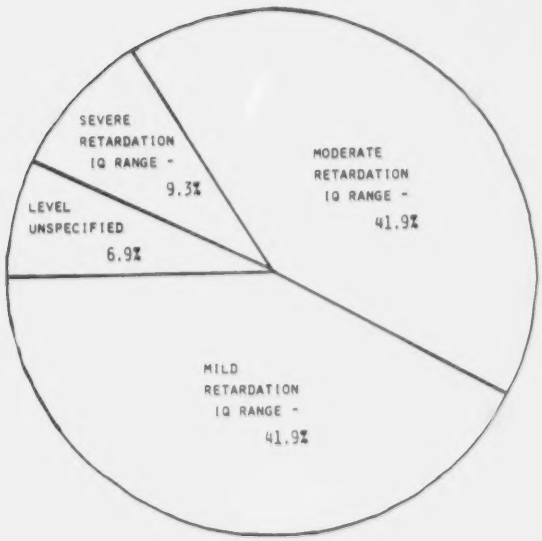
100% OF THE TIME.

COMPOSITE PROFILE

The typical MR/EH adult in this study is a twenty-five year old white male from an urban county and currently residing away from his home county in some type of institution. He is mildly to moderately retarded and is multiply handicapped --- most likely to have epilepsy or severe speech disorders.[17]

FIGURE 1

HOW RETARDED ARE THESE ADULTS?



50% HAVE OTHER HANDICAPS IN addition TO MR/EH, PREDOMINATLY EPILEPSY AND SPEECH DISORDERS.

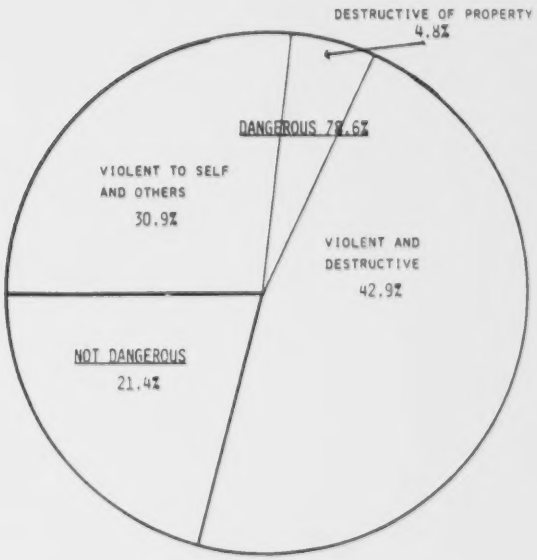
72% OF THE OFFENDER CASES HAVE OTHER HANDICAPS.

[17] Definitions/classes of Mental Retardation (IQ's), see p. 15.

Typically, his emotional handicap was first identified during his school years. He has been multi-handicapped and in the service system for much of his life. He has a history of dangerous behavior and has been violent to himself and others as well as destructive to property. He has had at least one incident involving the courts and has already been incarcerated or is considered at risk for correctional placement primarily due to his dangerous, assaultive behavior for which criminal charges could be sought.

FIGURE 2

HOW DANGEROUS ARE THESE ADULTS?



58% AT RISK FOR CORRECTIONAL PLACEMENT;

64% HAVE HISTORY OF COURT INVOLVEMENT IN CASES.

Whether or not this MR/EH adult had a history of abuse was not generally known to SCP&A, but if this history had been recorded, this individual had a one in three chance of having been abused as a child.

WHERE ARE THESE ADULTS LIVING?

At the time of the study these adults were currently residing in the following locations:

IN THE COMMUNITY			19 (44.2%)
at home		12 (27.9%)	
with parents	11		
with relatives	1		
in DMR Group Home		1 (2.3%)	
in boarding home		2 (4.7%)	
in private facility for unwed mothers		1 (2.3%)	
location unspecified		3 (7.0%)	
IN INSTITUTIONS			24 (55.8%)
at DMH		6 (13.9%)	
State Hospital	5		
Hall Institute	1		
at DMR		14 (32.6%)	
Pee Dee Center	1		
Whitten (Village) Center	2		
Midlands Center	6		
Coastal Center	5		
at Department of Corrections		4 (9.3%)	
Kirkland (Special Learning Unit)	3		
Watkins Pre-Release Center	1		
TOTAL			43 (100%)

This typical adult is either unserved or inappropriately served --- largely as a result of one of three circumstances:

1) he is institutionalized in either a DMR or DMH facility and lacks the needed services of the other agency, or

2) he is incarcerated in a correctional facility, where he is likely to be exploited or abused and not receiving appropriate mental health and mental retardation services, and needs a less restrictive or safer setting, or

3) he is living precariously in the community and cannot successfully participate in educational, vocational rehabilitation, out-patient mental health or mental retardation day programs --- either because he has difficulty accessing services, because he has been refused or terminated from services for his disruptive behavior, or because of his own refusal to continue in the few available programs that have been recommended or arranged for him.

WHAT ARE THEIR PROBLEMS AND NEEDS?

Problems and Needs Identification

After examining (1) the results of SCP&A's case documentation on these 43 adults (included in full at the back of this report as Appendix D, Data Analysis) as well as (2) the comments elicited from those interviewed for this study, several problems and needs surfaced; these focus on four major areas:

1. The needs of institutionalized MR/EH adults are not being properly met.

2. Incarcerating MR/EH adults is completely inappropriate.

3. Training opportunities for institutional and community-level staff are inadequate to improve their skills in serving MR/EH adults.

4. A range, or "continuum" of service alternatives capable of "caring" for MR/EH individuals does not exist.

5. Interagency planning and coordination of services on behalf of MR/EH adults in institutional settings and for those living in the community are only in their earliest stages of development.

The problems and needs of MR/EH adults, described below, are viewed from two broad perspectives: those of the institutionalized and those who live in the community.

IN INSTITUTIONS

For institutionalized adults, the predominant concern is either the inability to obtain mental health treatment services when confined in a DMR institution or the inability to obtain mental retardation developmental services while confined in a DMH institution. Thirty-five percent of the unserved or inappropriately served adults identified by this study were in this predicament.

DMR reports a total of 275 institutionalized mentally retarded individuals also having mental illness, and of these, 233 (84.7%) are 18 years of age and older. DMH reports having 511 mentally ill individuals residing in their in-patient facilities (on June 30, 1981) who had a primary or secondary diagnosis of mental retardation with only 14 (2.7%) being younger than 18 years old.[18] All of these 786 persons of which 730 (92.9%) were considered in the adult group may potentially have the same problems and needs as those institutionalized MR/EH adults examined during this study.

One of the primary stumbling blocks in appropriately serving the needs of severely MR/EH individuals was repeatedly cited throughout the interviewing; that is, the lack of planning and coordination that assures service continuity between DMR and DMH. It is obvious that MR and MH professionals alike are not taking full advantage of each others' expertise and the resources available to them in order to better serve these individuals, but more critical is the absence of formalized procedures to accomplish this.

DMR representatives say their staff is not properly trained to handle violent, dangerous or disruptive clients. Further, they may not be trained nor qualified to dispense special medication or adjust medication dosage levels for this type of problem. On the other hand, DMH staff members do not think they are properly trained either, nor do they feel they have the expertise

[18]"The Mentally Retarded and Mentally Ill Citizen: A Report to the South Carolina General Assembly", South Carolina Departments of Mental Health and Mental Retardation, December 1981.

to deal with MR individuals or to provide them with the developmental training services they need. However, the absence of such specialty training is to a great extent the result of the individual program staff's basic educational background and orientation.

A particular concern shared by DMR personnel during the study was that the majority, if not all, MR/EH persons institutionalized in DMR's facilities need sex education and routine counseling services. Psychiatric services are still lacking despite DMR's attempts to hire a psychiatrist.

DMR also admits that it does not have the capability to adequately deal with MR individuals who are also violent and dangerous in their programs and are uncertain as to how they should be restrained and prevented from harming themselves or others, while still affording them their legal rights. Consequently, DMR staff relies on "MH facilities" to refer these clients.

Whenever DMR refers an MR/EH individual to DMH's facilities, DMH evaluates the person and usually prescribes psychotropic medications, but can offer little other appropriate treatment; most stay at DMH less than thirty days. One DMR staff member interviewed for this study observed that sometimes the dosage of medication prescribed by DMH results in the person being "zonked out" and unamenable to DMR's developmental program, but whenever the medication is withdrawn, the person easily becomes disruptive again. Such comments zero-in on the necessity for a structured interchange on the individual clients' behalf between these two agencies.

As it is, the dual handicap of mental retardation and severe emotional handicap poses a crucial problem in determining which of the two agencies (DMR or DMH) is legally responsible for serving this type of individual. However, there has always been, and more than likely will continue to be, conflicting opinions from differing evaluators - one saying the primary diagnosis is mental illness and another saying it is mental retardation - and at times, the problem is further complicated by professional disagreements over whether an individual is indeed mentally ill or merely has a temporary or mild emotional disturbance.

Other serious problems regarding service provision and/or the management of referrals arise over delays in transfer of records from DMR to DMH and vice versa and the difficulties in obtaining successful MR/EH client admissions to some of DMH's in-patient facilities, notably the William S. Hall Psychiatric Institute and re-admissions to Bryan Hospital.

When interviewed, DMH personnel mentioned a variety of problems encountered in successfully gaining transfer of a rather sizeable number of their MR/EH clients into DMR's facilities and they maintain that these persons would be much better served at DMR. However, DMR indicates a substantial number of these individuals have lower priority on their agency's waiting lists because they already "have a bed" in one of DMH's facilities.

Confusion exists statewide regarding DMR's eligilibity requirements. DMR's criterion for client services is an I.Q. of 68 or less. As a rule, residential placement is primarily reserved for applicants who have severe or profound mental retardation in the 0 to 35 I.Q. range. Under certain special circumstances, however, DMR has accepted individuals with slightly higher I.Q.'s in these programs. Perhaps this is the reason why inability to gain admission to a DMR facility for an MR/EH individual was specifically noted by adult corrections as well as juvenile justice staff.

A number of judges remain upset and frustrated over the statute which limits the number of persons who can be placed at DMR although it is a fact that more beds than allowed by regulation cannot be created without jeopardizing Medicaid certification; thus, the unavailability of a sufficient number of DMR beds does occasionally result in inappropriate placement of MR individuals in DMH facilities. Law enforcement officers also continue to be acutely aware of and concerned over these placement issues since jail is many times the only immediately-available "facility".

Another problem primarily stressed by probate judges as well as family members of mentally ill persons is what is known as the "revolving door syndrome". They reported that they are constantly frustrated and concerned

because the same individuals are being committed to DMH's in-patient facilities time and time again. This area was likewise of great concern to nearly all state agency officials that were interviewed since discharge planning and follow-up services are critical aspects of care for severely emotionally handicapped individuals, but especially for those who are dually handicapped with mental retardation. This particular need was substantiated throughout this study in a number of cases where following release from either mental health, correctional or other residential facilities, clients failed to continue in the community programs which were pre-scheduled for them.

DSS reported that MR/EH individuals are being discharged from DMH's State Hospital with several weeks' supply of psychotropic medications and given an appointment with a local mental health center. Some do not keep their appointments, and when their medications run out they become disruptive again, a situation which usually leads to their re-commitment.

It is believed that such recidivism could well be prevented in a number of cases if the individuals were to receive proper after-care treatment and medications through their community mental health centers. For example, a 1978 Memorandum of Agreement between DMH and DSS specifies how the two agencies will cooperate to provide follow-up services to certain DSS clients who, after discharge from the hospital, fail to keep appointments with their local mental health centers; however, their agreement is not followed consistently across the state. It demonstrates the need for DMH and DSS to jointly identify the reasons why this has been occurring and to take the proper steps to correct it.

The myriad of problems inherent in the inappropriate institutionalization of a great proportion of these multi-handicapped individuals was also cited, primarily by Department of Corrections representatives who indicate that the courts continue to send MR individuals who are not dangerous to prison for security, safety or custody reasons, as one example, in cases of persons who, because of low intelligence and limited judgment, wander into other peoples' homes. Judges reportedly claim they would order these individuals somewhere other than to prison, but no appropriate alternatives are known or available to them.

Department of Corrections officials feel that placing MR adults with the general prison population not only is "counter productive" for them, but also places them at very high risk for abuse by other inmates. A great number of these individuals have adaptive behavior and I.Q.'s which are too high for admission to a DMR residential center, but they have an I.Q. too low to function in a correctional setting. Department of Corrections facilities are severely overcrowded; do not have the resources to meet the special needs of individuals who are both MR and EH; and Corrections personnel firmly believe it is harmful to place mentally retarded persons in prison. They say "some go crazy after entering the prison system."

"BRIDGING THE GAP"

The wholesale "dumping" of mentally retarded and/or mentally ill persons into the community, which has taken place with such disastrous results in recent years in states like California and New York, has fortunately not been practiced in South Carolina; yet, a few isolated incidents have already occurred. One private citizen who recently contacted the P&A System described finding an MR/EH adult searching desperately in a garbage can for food. This young man had been discharged from one of South Carolina's institutions but had been sleeping on the streets for several weeks after having been thrown out of his own parents' home.

Incidents such as this one pinpoints the reason why so many MR and/or EH individuals either become victimized or get in trouble with the law. Due to the impending threat of continuing federal and state cut-backs, the current reality is that MR/EH individuals in South Carolina could well be de-institutionalized from both DMR and DMH facilities without providing them the proper support in the community.

In a nutshell, one of the major problems of service delivery to the MR/EH population in South Carolina stems largely from the fact that they unfortunately have two or more major handicaps in a system designed to deal with only one handicap at a time. And when these individuals have additional disabilities over and beyond the dual handicap of MR/EH, they are even more vulnerable for developing serious emotional disorders. They tend to blow

up, resulting in real difficulties and frustrations for the service agency personnel who are held accountable for helping them. The sad truth, however, is that these types of individuals as well as their caretakers are both at the mercy of an ill-prepared services network.

Moreover, such systemic problems are magnified by the different perspectives of the two, and often more, disciplines which may become involved in the care and treatment of persons with multiple disorders. For example, the focus of MR professionals is that of life-long services, whereas MH professionals emphasize short-term crisis intervention, except in the cases of those who are chronically mentally ill. The approaches are so different that these two types of professionals even talk a different "lingo" and very few of them have had the benefit of cross-training in both disabilities.

Members of "Families and Friends of the Mentally Ill" voiced their real concern over the lack of training of both mental health and mental retardation staff in dealing with this dually-handicapped group. Clearly, interagency training opportunities for both institutional and community personnel, which have been advocated in the past, are again a pressing need. To quote from a recent letter received at the P&A System: "The well-being and happiness of our loved ones are too precious to be entrusted to unqualified, untrained personnel."[19]

[19]Letter written by a concerned parent.

IN THE COMMUNITY

The issue of I.Q. levels was also raised during the interview process as a community services problem, specifically, by parents of MR adults. They are afraid that some of these individuals could well be terminated from community mental retardation programs because their I.Q. levels may be higher than those established by recent DMR directives, despite the fact that they have been served there for a number of years. Concern was voiced that if these MR/EH adults were terminated, they would be at high risk for suffering severe emotional problems, and of course, this is a legitimate concern given the lack of any other day activity programs to accommodate them in the community.

The dire need for a broad array of community-based services has repeatedly been pinpointed for those MR/EH persons who do not have a structured home to offer them supervision and guidance and who are at greatest risk for becoming a problem in the community. Special problems are presented when family members are disinterested, become too old or disabled, or are otherwise unable to properly care for these individuals. While this is primarily a problem with MR/EH adults, this is also a grave concern with the group between 17 and 21 years of age. It appears that the existing community mental health center network throughout the state can offer medication and crisis stabilization but little other on-going and needed day treatment services. And, the other state agencies in South Carolina who are by law also responsible to serve these MR/EH persons, i.e. DSS, DVR, Aging, etc. are likewise ill-equipped, singly, to meet their individual needs without the full cooperation and support of each other.

The problems reflected in P&A's case documentation appear to be compounded in the community by the frequent inability to obtain compliance on the part of the client to participate in those sparsely available service programs which have been negotiated or arranged for him/her.

A comprehensive range of service alternatives such as day activity centers, client training in living skills, group homes and halfway houses, to name only a few, will be necessary for there is a dearth of such resources in the state. For those whose families cannot or will not care for them, community residential placements will be needed, particularly in cases of MR/EH offenders who are released from prison without support and guidance and are at high risk for re-incarceration.

The State Department of Corrections has noted the important need for community-based treatment facilities for these adults, in the belief that many MR/EH individuals could and should be removed from prisons and placed in the community with appropriate support and supervision, while others will need specialized programs in a restrictive, but safer, environment. However, as pointed out by officials of the State Department of Parole and Community Corrections, the ex-offender label attached to these individuals often causes them to receive lower service priority due to negative attitudes toward ex-offenders. This represents a barrier that must somehow be overcome if these MR/EH persons are to be appropriately served.

The need for expanding local services was also echoed by the Department of Social Services and they insist it must include emergency shelters. Law enforcement officials are often confronted with the urgency of relieving the community of MR/EH adults (and youth) who cause problems in their neighborhoods, but many times they have no alternative but to place them in jail, even though such placement is inappropriate in view of their mental handicaps.

There is another important reason for establishing such facilities. DSS is responsible for receiving and investigating reports of abuse or neglect, including the MR/EH adult, but it cannot develop these shelters itself because the agency is currently under a mandate to withdraw from the operation of "residential" facilities. Consequently, both its child and adult protective service workers are at a loss as to how to provide effective protective services to their clients without these needed emergency facilities.

Community mental retardation programs scattered throughout the state encounter particularly significant problems in serving MR/EH individuals. During this study, meetings were held with a selected number of directors of these community MR programs in order to ascertain the extent of (1) their concerns in serving the severely emotionally disturbed client and (2) their cooperative relationships with mental health centers in their area. The respondents unanimously agreed that dealing with the severely emotionally disturbed caused them critical and serious problems; of their total MR clientele, 10% to as many as 33% of the adult group were judged to be severely EH and/or in need of mental health services.

They reported inadequate training of existing staff and no special programs to deal with the behavioral problems of MR clients; also, the absence of any guidelines for determining agency responsibility when MR clients require mental health services. It is interesting to note that personnel of five of the twelve DMR programs interviewed for the study (See Chart 1) currently have no relationship with community mental health centers. Four of these programs, however, have cooperative arrangements for medication check-ups and group or individual counseling services.

Despite their willingness, community mental health center directors reported that substantial loss of revenue over the last several years has caused severe reductions in personnel which, in turn, has lessened their capabilities to provide the specialized services required by the MR/EH individual. For example, in the past two years alone Charleston's Community Mental Health Center has been reduced from a staff of 70 to 37. Additionally, they admit that the few mental health professionals that are left have not been trained to provide the specialized treatment necessary for MR clients.

Community MH professionals have noted that when MR individuals become adults, their low intellectual and tolerance levels and their inability to compete causes them to be easily frustrated, anxious and depressed; this is compounded by the fact that they may then become more difficult to manage at home, while at the same time there are virtually no services available in the community to meet their needs.

CHART 1

Program	Number of MR/EH clients in need of MH services (% of clients) Child	Adult	Perceived quality of relationship with CMHC	Type of MH services received	Problems with MH services and other problem concerns
Sumter	3 (10%)	12 (22%)	OK	Counseling at MHC	have requested CMHC to do sessions, on-site receiving referrals from parents, schools and MH of unmanageable, out-of-control children who are being expelled from public school because of attendance and behavior problems
Clarendon County	-	8 (31%)	Good	free medication check-up and regulations	when crises occur, neither DMR or DMH wants to assume responsibility for client; need guidelines for action when severe psychotic behavior occurs in MR client - perhaps DMR-DMH mutual agreement
Barnwell County	-	6 - 10 (10-15%) (violent)	-	None	need consultation assistance from CMHC staff
Charleston (Hope Center)	-	25 (15%)	Good	MHC are referring MR clients and providing medication to their clients	has had to discharge at least ten clients due to severe violent behavioral problems. CMHC is cooperative and willing to help, but does not have the staff nor financial resources to offer this service
Greenville (Hollis Center)	15 severe preschool MR/EH	-	-	none mentioned	successful program with guidance-trained aides; 5 kids per class - secret is daily tightly structured - one-to-one trust established; involvement with parents
Winnsboro	2 (14%)	-	none	none	no help received
Lee County	-	7 (23%)	none	none	very little/no help from local MH clinic
Hartsville	19 total	8 (33%)	OK	medication group therapy	occupational therapy has one severe EH child MR/MH clients transported to MHC for medical check-up once a month group therapy done monthly on-site
Bamberg Adult	-	3 (10%)	OK	medication group therapy	medical check - twice monthly group therapy - twice monthly
Greenville (Piedmont Skills)	-	40 (25%)	none	no services received	*4 currently violent - others terminated for violent and destructive behavior; some are served individually but none through the MR program
Green Manor (Pied Piper)	5 autistic	20 (33%)	OK	unspecified	staff are not trained to handle MR/MH adults attend MH center; more accurate diagnosis of MH children served as needed on request
Aiken	4 (5%)	-	OK	consultation	using aversive training for 4 under supervision of DMR psychologist

BEST COPY AVAILABLE

A critical period occurs when the former MR student, who has been provided an array of activities and inter-personal relationships through the public schools is suddenly without such supportive programming and he is thrust upon a community which makes no provision for activities for people who deviate from the norm. While his former classmates are continuing their educations, entering the work force, and getting married, this MR individual, now a young adult, has time on his hands and nothing meaningful to do. The chances that he will get into some sort of trouble are increased dramatically.

Unless South Carolina becomes more responsive to these individuals, they will continue to "fall through the cracks", more often than not, provoking problems in the community which could easily bring them to the attention of the courts.

HOW CAN WE SOLVE THEIR PROBLEMS?

Recommendations

There are no clear-cut or easy solutions to the problems experienced by this group of handicapped individuals who are affected by severe emotional disturbances, combined with mental retardation, and often, a variety of other disabilities --- because their needs are unique and because the state's service delivery system was organized to accommodate a "categorical" or single handicap, rather than the "functional" or comprehensive needs of the individuals it set out to serve. These problems are felt most desperately by parents; where can they turn to find help for their disturbed and retarded offspring when appropriate care and services don't even exist in South Carolina?

As one authority has pointed out, many times these MR/EH individuals are "winding up in jails when they belong elsewhere in a proper treatment setting..., and it is getting worse because judges have lost confidence in the...system, and corrections is staggering under a burden for which they are unprepared and untrained.[20] This is the case in South Carolina as it is in other parts of the country.

[20]Keynote address at an April, 1980 Conference on the Needs of Emotionally Disturbed/Developmentally Disabled Individuals in Ellenville, New York by Assemblywoman Elizabeth A. Connelly, Chairperson of New York State Legislature's Mental Health Committee, who also noted that the mentally ill and retarded handicapped, especially, "...have no single agency to speak for them and so they 'fall between the cracks,'...recent investigations reveal bureaucratic indifference, disagreement by experienced professionals over basic diagnoses and sometimes changing diagnoses to fit a program or to prohibit entry into a program. It's been very frustrating for me...seeing the same scenario being played out time and time again. Nobody seems to want these poor people...a monumental problem that has been allowed to exist for too, too long."

The only clear concensus that emerged from the interviews with agency personnel and many others during the course of this study was that incarceration is an utterly inappropriate setting for those individuals who are MR and EH. Locking them away in the back wards of either DMR or DMH institutions is not a reasonable alternative either. What these people really deserve is a "continuum of services" which will permit an array of treatment and supportive services that are creative and flexible enough to satisfy their individual needs in the least restrictive environment. Usually, whenever individual members of society are better served, the community as a whole is better served.

Certain out-of-state professionals advocate for the MR agencies in the states being designated responsible to serve the comprehensive needs of this group of adults rather than the MH agencies, claiming that "they can do a better job." That may be, but what is exceedingly clear is that it is incumbent upon South Carolina as a state to resolve these problems--- regardless of which state agency ultimately takes the lead in providing services to this target population.

Some proponents of the case coordination/management concept of "brokering" services see it as a panacea for resolving these serious problems, but that in itself is not the entire solution. Although case management is definitely an essential "key" in improving human services, it is but only one element in an effort requiring unprecedented cooperation and coordination among the multiplicity of related state agencies which exist in South Carolina.

Many of the inadequacies in South Carolina's human services system which have been identified by this study have been described historically in previous investigations. Significantly, similar issues have been the subject of extensive litigation in other states.

One of these law suits, Knott -vs- Hughes, first filed in 1980 by the Maryland Advocacy Unit for the Developmentally Disabled, i.e., Maryland's P&A System, alleged, among other things, that the members of the plaintiff class of mentally retarded/mentally ill individuals were illegally and inappropriately confined in mental institutions in Maryland. Later, in 1981, another suit was filed where it was claimed that a group of institutionalized MR individuals with significant mental health needs were still not being appropriately served. The defendant state agencies conceded both issues and submitted plans to provide appropriate placements and/or improve services for the plaintiffs.

What is now known as the "Knott Plan" constituted the first attempt by the State of Maryland to fashion needed services for these individuals---a heterogenous group with complex physical and mental health problems. Many of them were found to have complicated medical difficulties, with speech and hearing disorders, diabetes and seizures being the most common. As a group, they had each been institutionalized an average of fifteen years, ranging from several months to fifty-two years.

In Maryland's case, "One of the historical problems in treating mentally retarded clients who have significant mental health needs has been a lack of coordination between..., the two state agencies which serve mentally ill and mentally retarded clients."[21] This finding holds true for South Carolina as well.

The Maryland response provided that "higher functioning" individuals should be placed in community settings and that limited - but substantially expanded - financial resources should be used to maximize the number of persons who would best be served in community programs, while it also recognized that not all class members could function successfully in the community. The cornerstone of the 1980 Knott Plan was a thorough evaluation

[21] William J. Grabau, et al -vs- Harry R. Hughes, et al, Civil No. Y-81-1582 of Federal District Court, Maryland.

process to first determine the appropriate placement needs of these individuals, as recommended by an inter-disciplinary staffing team. The services were developed and are now being provided jointly by the Maryland Department of Health and Mental Hygiene, the Department of Human Resources, and the Department of Education, resulting in a slow, but steady number of placements and new services to date.

As previously highlighted in PART I of this report, the State of North Carolina has also been under court order to provide special services to youngsters identified as members of the "Willie M. Class"---severely emotionally disturbed, violent children and adolescents who could find no appropriate program in North Carolina's services system. And, interestingly--- without the benefit of any law suit ---the states of Tennessee and Florida are both attempting to develop programs in an honest effort to tailor-make services to meet the specific requirements of MR/EH adults.

South Carolina has a unique opportunity to build on the various experiences and service programs that have been developed and are already operating, often through trial and error, in these other states.

RECOMMENDATION ONE: SOUTH CAROLINA SHOULD TAKE IMMEDIATE ACTION TO DETERMINE THE "LEAD" AGENCY IN ORDER TO PROCEED TOWARD ESTABLISHING THE COORDINATED CONTINUUM OF SERVICES NEEDED BY THESE ADULTS.

Although no legal actions have yet been filed on behalf of similar classes of persons in South Carolina, the state is ENCOURAGED TO MOVE IN THE DIRECTION OF RESOLVING THE PROBLEMS AND FULFILLING THE NEEDS ON BEHALF OF THESE ADULTS BEFORE LITIGATION DEVELOPS. It would be fiscally unsound to spend scarce service dollars on legal costs of such actions (that figure was more than half a million dollars in North Carolina's "Willie M." case last year alone).

TASK FORCE

A NECESSARY FIRST STEP in this process is seen as the CREATION AND APPOINTMENT BY THE GOVERNOR OF A TASK FORCE whose overall responsibility should be a state-wide action plan for establishing a coordinated continuum of services for this dually-diagnosed population and for following up and assuring its implementation.

Appointing a Task Force

The Task Force must be COMPOSED OF THE MAJOR GROUPS IN THE STATE WHICH HAVE THE GREATEST INVESTMENT AND INTEREST IN THIS COMBINED MR AND EH POPULATION --- at a minimum, selected members of the Joint Legislative Committee on Mental Health and Mental Retardation, the Commission on Mental Health and the Commission on Mental Retardation, as well as key staff representatives of both of these state agencies.

The Governor should APPOINT AT LEAST ONE OTHER MEMBER, representing the public at large, TO SERVE AS CHAIRMAN OF THE TASK FORCE AND TO PROVIDE THE GOVERNOR'S OFFICE WITH ON-GOING PROGRESS REPORTS of the Task Force's activities.

In order to maximize the productivity of the Task Force, it is also recommended that the Governor's Office assist the Task Force in securing needed staff support for the duration of their tenure. One possible resource could be the MH and MR Committee.

Naming a "Lead" Agency

Not only is it appropriate, but ESSENTIAL THAT AS ITS FIRST ORDER OF BUSINESS, THE MEMBERS OF THIS TASK FORCE REACH AN EARLY DECISION ON WHICH OF THESE TWO STATE AGENCIES (DMH or DMR) WILL BE DELEGATED THE LEADERSHIP ROLE in serving individuals who are both MR and EH since SUCH A DETERMINATION MUST BE CLEAR AND FIXED. It is obvious to even the most casual observers that the long-standing controversy over which one of these two agencies is legally responsible for this population must be resolved. The fact is that both of these "primary" agencies are by law responsible to serve the MR/EH individual and, as anyone well knows, whenever more than one agency is responsible, the end result is that no one is responsible.

It is high time for the State of South Carolina to face up to perennial realities, flip that coin, and choose one or the other, while at the same time being mindful of which of these two agencies has the most to offer these MR/EH individuals. Before making the final determination, the Task Force must know that by virtue of its

legal mandate, DMH is saddled with a "medical model," enabling that agency to obtain improved response by their clients through a combination of intensive treatment and psychotropic drugs, but that it has very few other programs designed for MR persons. Whereas DMR is based on a "developmental/psycho-educational model," with programs that emphasize behavioral, counseling and educational activities and which are basically in place both in its institutions and in the community, but which lack the required psychiatric expertise to deal successfully with the combination MR/EH client.

Regardless of which one of these agencies takes the lead, there must be assurances that appropriate staff and financial resources will be committed to this needed "continuum of services".

Legislative Mandate

It should be the RESPONSIBILITY OF THE TASK FORCE TO DETERMINE THE NEED FOR, AND IF NECESSARY, PREPARE APPROPRIATE AMENDMENTS TO STATE STATUTE(S) for presentation and subsequent introduction in the State Legislature.

Legislative amendments for THIS "CONTINUUM OF SERVICES" SHOULD GUARANTEE THAT ALL OTHER RELATED STATE AGENCIES PARTICIPATE WITH THE "LEAD" AGENCY ---as a team--- in planning and implementing needed service programs on behalf of MR/EH individuals.

"LEAD"/ADMINISTERING AGENCY

Evaluation Procedure

Once the "lead" agency has been determined, the NEXT LOGICAL STEP is to ACTUALLY DESIGN A WORKABLE PROCEDURE WITH WHICH RELEVANT STATE AGENCIES CAN AGREE IN ORDER TO (1) IDENTIFY AND DETERMINE ELIGIBILITY FOR MEMBERS OF THIS DUALLY-DIAGNOSED GROUP AND (2) TO ASSESS AND JOINTLY ARRIVE AT THE HABILITATION NEEDS OF THESE MR/EH INDIVIDUALS. One such diagnostic tool has been developed in the State of Maryland and close review of that process could be invaluable in formalizing such a mechanism in South Carolina.

Whichever procedure is eventually selected, it could be effectively utilized for bringing together the necessary "mix" of service agency representatives to benefit the individual MR/EH adult who is in need of services.

Moreover, such a process could be utilized to excellent advantage as a planning tool in pinpointing service "gaps" in the current human services system. This should not only prove to be sensible, but would yield the ideal vehicle for substantiating any future programs and financial resources before the members of the General Assembly.

RECOMMENDATION TWO: SOUTH CAROLINA SHOULD TAKE IMMEDIATE STEPS TO DESIGN, INITIATE, AND EVALUATE A MODEL PROGRAM FOR INSTITUTIONALIZED MR/EH ADULTS.

THIS INSTITUTIONAL PROGRAM should be ADMINISTERED DIRECTLY BY THE "LEAD" AGENCY TO SERVE A SMALL NUMBER OF CLIENTS. For best results, however, it is recommended that this model be DESIGNED IN SUCH A WAY AS TO (1) UTILIZE EXISTING SPACE RATHER THAN CONSTRUCTING ANY NEW BUILDINGS AND (2) MAXIMIZE THE EXISTING STAFF RESOURCES OF ALL RELATED AGENCIES IN A SINGLE, JOINTLY-STAFFED PROGRAMMATIC EXPERIMENT. It is expected that both DMR and DMH, as the two "primary" agencies involved, would enhance and strengthen the manpower and expertise of the other by mutually-designing and providing "special" training modules and other needed treatment services for these MR/EH adults.

As recommended in the children and adolescents' section of this report, South Carolina should FULLY INVESTIGATE PROGRAMS WHICH EXIST IN OTHER STATES PRIOR TO EMBARKING IN THIS NEW VENTURE. Special programs for MR/EH individuals are scarce throughout the country since this is a brand new field of endeavor, but several southeastern states have recently started developing these types of programs. One such facility, the Winston Developmental Center, is located at Western Institute in Tennessee; it is a residential treatment program designed primarily for MR individuals with extensive MH needs. In the State of Florida, MR officials there are presently in the throes of developing a special in-patient program despite the fact that they felt that community-based programs were of paramount importance for MR/EH individuals.

Sadly, the picture for MR/EH adults is as bleak, if not worse, in cases of those who reside or are discharged into the community since traditionally, many South Carolina officials have viewed "institutional beds" as the only answer. This has thereby resulted in a reduced availability of sorely needed community-level services when, of course, it is apparent that what we really need is to move away from this "old" approach and strive toward enhancing a creative array of choices in the community.

About two years ago, representatives of DMR's Coastal Center and the Charleston Community Mental Health Center came together in an effort to assist a group of about 35 MR/EH individuals in the Charleston area. What was expected to be a series of very productive meetings ended up in the development of a program plan, but no more, since their suggestions were never implemented. It has been stated that due to the lack of funds at that time the project was relegated to a low priority. The group worked long and hard and had recommended a day treatment program serving MR/EH adults (known to both agencies) to be started in the Charleston community, collaboratively, through a shared cost and staff arrangement. Another jointly-staffed program was also recommended by this same group for a community residence to house a small group of these dually-diagnosed adults.

RECOMMENDATION THREE: SOUTH CAROLINA SHOULD TAKE IMMEDIATE ACTION TO DESIGN, INITIATE AND EVALUATE A MODEL PROGRAM FOR MR/EH ADULTS IN THE COMMUNITY.

Because of the demonstrated interest and groundwork that has already been laid, it would make sense to LOCATE SUCH A MODEL PROGRAM IN THE CHARLESTON COMMUNITY as a key component of the "continuum of services" program. By building upon these previous experiences and by taking advantage of newly-revived efforts to extend the Developmental Disabilities Program's Case Coordination capabilities into the Tri-County area of the state (Charleston, Berkeley and Dorchester counties) on behalf of this MR/EH population, the possibility of success for such a program will be enhanced.

This model program should INITIALLY INCLUDE A DAY TREATMENT PROGRAM TO BE COMPLEMENTED, SOON THEREAFTER, BY A COMMUNITY RESIDENCE. To achieve this will require continuing close involvement of the DD Case Coordination Program, DMR and DMH, along with local representatives of, at a minimum, DSS and Vocational Rehabilitation. Under the direction of the "lead" agency and WITH A RELATIVELY SMALL CONTRIBUTION OR RE-DIRECTION OF FUNDS DRAWN FROM THE RESPECTIVE BUDGETS OF EACH OF THESE STATE AGENCIES, the day treatment component of this model community program could easily become a reality within a year.

One option to consider would be to contract the day activities to either of several private vendors of services in the Charleston area, for example, either the Hope Center or Goodwill Industries, with the proviso that appropriate mental retardation and mental health services be designed

specifically in the curriculum to respond to the educational, vocational and recreational needs of these MR/EH adults. Intensive living and "coping" skills as well as sexual awareness education should be included in the program and staff must be trained to prevent and manage aggressive client behavior.

Other essential components in the needed "continuum of services" are improved medical care, respite care and a strengthened outreach program to support families in crises. All of these services should be aimed toward enabling these individuals to cope as effectively as possible in the least restrictive environment.

One community program for MR/EH individuals in Silver Spring, Maryland has been recognized as one of the very few in the nation which provides innovative, comprehensive programming (see Rock Creek's Program Services in Appendix E). This privately-owned program was started several years ago in order to help persons who are handicapped by both mental retardation and mental illness. Because this particular community program should not be overlooked as a valuable resource, it is recommended that the KEY PARTICIPANTS WHO BECOME INVOLVED IN DESIGNING THIS MODEL PROGRAM FOR SOUTH CAROLINA (INCLUDING THE MEMBERS OF THE TASK FORCE) MAKE A MANDATORY ON-SITE VISIT TO VIEW THE ROCK CREEK OPERATION FIRST HAND.

RECOMMENDATION FOUR: SOUTH CAROLINA SHOULD ALSO DESIGN, INITIATE AND EVALUATE PROGRAMS TO SERVE THE NEEDS OF MR/EH ADULTS WHO GET IN TROUBLE WITH THE LAW.

Community Residences

Both the State Department of Corrections and the Department of Parole and Community Corrections have pointed out the dire need for special programs for MR/EH offenders; therefore, it is recommended that THESE TWO AGENCIES TOGETHER PROVIDE THE NECESSARY INPUT TO THE "LEAD" AGENCY IN THE DESIGN OF A COMMUNITY RESIDENCE WHICH WOULD SERVE AS AN ALTERNATIVE TO INCARCERATION OR AS A TRANSITION TO COMMUNITY LIVING. By way of recent enabling State legislation, funds from the Department of Parole and Community Corrections are currently available to "purchase services" on behalf of ex-offenders, including those who are handicapped. Such funds could help support this model program.

IN ADDITION, South Carolina's Alston-Wilkes Society and other programs such as the existing DMR or DMH vendor programs should be ENCOURAGED TO EXPAND THEIR SERVICES TO EMBRACE THIS PARTICULAR TARGET POPULATION.

Other Community Support Services

IN ADDRESSING THE OVERALL NEEDS OF MR/EH ADULTS IN THE COMMUNITY, THE PRIVATE OR VOLUNTARY SECTOR SHOULD NOT BE OVERLOOKED AS A VIABLE RESOURCE.

Recently, in Horry County a community-wide effort has been initiated in hopes of developing more appropriate service alternatives for MR individuals who get in trouble with the law. The Horry County Association for Retarded Citizens (ARC), along with a group called "Volunteers in Probation," have already been a catalytic force in attempting to resolve the problems and needs of MR persons who run afoul of the law.

These citizens have been working with concerned representatives of Alston-Wilkes, DD Case Coordination, DSS, DMH, DVR, DMR, DYS, schools and police, jails, as well as church groups and the P&A System. These groups represent a myriad of disciplines. Meetings have been scheduled, and are currently being held, to brainstorm a "united plan of action" for Horry County to muster and coordinate available resources and develop additional alternatives to better serve these individuals.

Horry County's ARC is not the only volunteer group in South Carolina that has pressed for change in this arena; it is merely one example of an effort in the Pee Dee Region of the state which points dramatically to the positive force a voluntary group can have on complex community problems. Local ARC's, Mental Health Association chapters and the many other existing volunteer groups across the state should be encouraged to take similar leadership roles in promoting the needs of this neglected population and to help mobilize the "continuum of services" needed by MR/EH adults in each and every community in South Carolina.

"FILLING IN THE CRACKS"

MAY BE ONE OF THE GREATEST CHALLENGES THAT WE IN THIS STATE MUST FACE---

both in the private and the public sector.

By responding to the needs of South Carolinians,

who because of their multiple handicaps have proven

to be the most difficult to serve, the human service

delivery system's hand will be forced to become

tremendously creative and flexible in its approach.

If we are fortunate, TOGETHER,

WE WILL SUCCEED IN ESTABLISHING THE COORDINATED

"CONTINUUM OF SERVICES" NEEDED BY THESE INDIVIDUALS.

Appendix A

DATA ANALYSIS

Emotionally Handicapped Children and Adolescents

Procedure

A total of 168 cases of children and adolescents having an EH designation were initially identified from the 1979-81 case files of SCP&A. Cases in which the primary diagnosis was autism were discarded from the study as were cases that could be readily identified as not severely emotionally handicapped or for which information was insufficient. A total of 45 cases were discarded. A data collection instrument was developed for the study and information from the written records in the clients' file was recorded. Interviews with SCP&A advocates were also conducted to gain more complete information. Some cases had extensive files, including evaluations and school records, others had little information largely due to the limited P&A involvement in those cases. Where information was not available, questionnaire items were marked "unknown".

Table I shows the total number of 123 cases included in the study by SCP&A regional and offender advocate program. Cases were categorized by primary diagnosis MR/EH or EH (37%) (63%); subsequently, however, this was recognized as a less than descriptive classification since a preponderance of the EH cases evidenced some level of retardation or other developmental disability. Seventy-four percent of the cases had been served through the regional offices of SCP&A; twenty-six percent were from the Offender Advocate's caselcad.

Table I
Number and Percent of Cases

Category	MR/EH	EH	Total/(Percent)		Discard Autism	Discard Not Severe EH
Case Source						
Regional Offices	33	58	91	(74.0%)	33	11
Offender Advocate	12	20	32	(26.0%)	0	1
Total	45 (36.6%)	78 (63.4%)	123	(100%)	33	12

Distribution of Cases by Type and Level of Handicap

The original case classification, by primary diagnosis, MR/EH or EH, proved to be somewhat misleading on closer examination of the types of handicaps exhibited by these children. Table II shows the breakdown and percent distribution of handicaps. It is immediately clear that these are predominantly multi-handicapped children. Only 18.7% had the single handicap of emotional disturbance; 81.3% had at least one handicap in addition to the emotional disorder and nearly one-third had two or more in addition to EH. Mental retardation was most predominant with 47.2% suffering that disorder, and 56% of the Offender group was mentally retarded. Table II-A shows the distribution of levels of retardation. Of all MR cases, about a third are mildly retarded and 22% are moderate; 10% are severe-profound. The Offender cases are more likely to be borderline or mildly retarded while the regional cases are more likely to be at the moderate level, and none of the severe cases were in the Offender group.

Of the other handicaps, learning disabilities (19.5%), epilepsy (13.8%) and hyperactivity (14.6%) are the most frequent. Visual, speech and hearing disorders and some brain damage are each present in 5 to 10% of the youngsters. The presence of additional handicaps affects 79% of the regional cases and 87.5% of the Offender Advocate's caseload.

Table II
Distribution of Cases by Type of Handicap

Handicap	Regional Cases n=91		Offender Cases n=32		Total n=123	
	Number	Percent	Number	Percent	Number	Percent
Total Children EH only	19	20.9	4	12.5	23	18.7
Total with at least one additional handicap	72	79.1	28	87.5	100	81.3
Mental Retardation	40	43.9	18	56.2	58	47.2
Learning Disability	18	19.8	6	18.7	24	19.5
Hyperkinesis	11	12.1	7	21.9	18	14.6
Epilepsy/Seizures	12	13.2	5	15.6	17	13.8
Speech	10	11.0	3	9.4	13	10.6
Brain-Neuro damage	5	5.5	2	6.3	7	5.7
Hearing	4	4.4	2	6.3	6	4.9
Autistic Tendency	6	6.6	0	0	6	4.9
Visual	5	5.5	0	0	5	4.1
Orthopedic	2	2.2	1	3.1	3	2.4
Obesity	2	2.2	0	0	2	1.6
Spina Bifida	1	1.1	0	0	1	0.8
Cerebral Palsy	1	1.1	0	0	1	0.8
Total with three or more handicaps including EH	30	33.0	9	28.1	39	31.7

Table 11-A
EH Children and Adolescents Who Are Also MR

MR Level	Borderline		Mild		Moderate		Severe/Profound		Unspec.		MR Total	
Number	11		20		13		6		8		58	
Percent of all MR cases n=58	19.0		34.5		22.4		10.3		13.8		100.0	
Percent of all EH cases n=123	8.9		16.2		10.6		4.9		6.5		47.2	
MR Levels	#	%	#	%	#	%	#	%	#	%	#	%
Regional Cases n=91	5	5.5	9	9.9	12	13.2	6	6.6	8	8.8	40	43.9
Offender Cases n=32	6	18.8	11	34.4	1	3.1	0	0	0	0	18	56.3
MR Offender Cases n=18	6	33.3	11	61.1	1	5.5	0	0	0	0	18	100.0
MR Regional Cases n=40	5	12.5	9	22.5	12	30.0	6	15.0	8	20.0	40	100.0

Case Distribution by Region and Home Counties

Cases in the study represent 36 of the 46 South Carolina counties. A child's home county, however, only indicates the widespread dispersion of these children across the state. It in no way indicates the present location of the child. A tally of the discrepancy between home county and current county of residence was made to ascertain the extent of out-of-county (or out-of-state) placements. Results are shown in Table III.

Nearly 60% of children were currently residing in their home county, while 35% were out-of-county or out-of-state. Whereabouts of another 6.5% were not known. A much larger percentage of the Offender Advocate's cases were residing out-of-county (43.7%) largely due to the centralized location of the DYS facilities. Twelve percent of these cases were out-of-state.

Table III
Number and Percent of Children Currently Residing
Out-of-Home County

Current Residence	Out-of-County		Out-of-State		Unknown		In Home County	
Case Type	No.	%	No.	%	No.	%	No.	%
Regional n=91	21	23.1%	4	4.4%	8	8.8%	58	63.7%
Offender Advocate n=32	14	43.7%	4	12.5%	0	0	14	43.7%
Total n=123	35	(28.5%)	8	(6.5%)	8	(6.5%)	72	(58.5%)

Residence in home county, however, does not assure the child is receiving services there as will be shown in later discussion. Table IV shows the county distribution of cases. The home county of several children was in dispute due to confusion regarding custody. Youth 19-21 from the MR/EH adult study are included in this table since this age group is still eligible for educational services from their respective school districts.

Table IV

Home County	Children and Adolescents	Adults 19-21	Total
Aiken	8	0	8
Anderson	5	0	5
Abbeville	1	0	1
Bamberg	2	0	2
Berkely	0	1	1
Beaufort	1	0	1
Charleston	10	3	13
Cherokee	2	0	2
Chester	2	0	2
Chesterfield	4	0	4
Clarendon	1	0	1
Colleton	1	0	1
Darlington	2	0	2
Dillon	1	0	1
Dorchester	6	1	7
Edgefield	1	0	1
Fairfield	1	0	1
Florence	11	3	14
Georgetown	2	0	2
Greenville	5	1	6
Greenwood	1	0	1
Horry	3	2	5
Jasper	1	1	2
Kershaw	1	0	1
Lancaster	2	0	2
Lee	1	0	1
Lexington	10	0	11
Marion	2	0	2
McCormick	1	0	1
Newberry	1	2	3
Orangeburg	1	0	1
Pickens	2	0	2
Richland	13	2	15
Saluda	5	0	5
Spartanburg	9	0	9
York	2	0	2
TOTAL	120	14	

*Transient or home county in dispute 3

Not represented in cases: Williamsburg, Marlboro, Oconee, Laurens, Sumter, Calhoun, Barnwell, Hampton, Union Allendale

* 1) M Darlington F Richland - joint custody - residence DYS
  2) F York M Georgia - TPR - adopted Ga., but from Charleston Family Court - back to S.C.
  3) transient - current residence Spartanburg

Tables V and VI show the distribution of cases by race and sex. Approximately 72% of the children are white and 26% are black with slightly over 2% other or race unknown. The Offender caseload has a higher percent of black children than the regional cases.

Almost three-fourths (73.2%) of the cases are male and 27% are female. The Offender caseload has a slightly higher percentage of males.

Table V
Distribution of Cases by Race
Children and Adolescents

Race	Black		White		Other		Unknown	
Case Source	No.	%	No.	%	No.	%	No.	%
Regional n=91	22	24.2	67	73.6	2	2.2	0	0
Offender n=32	10	31.2	21	65.6	0	0	1	3.1
Total	32		88		2		1	
Percent		26.0%		71.5%		1.6%		0.8%

Table VI
Regional Distribution of Cases by Sex
Children and Adolescents

Sex	Male		Female	
Case Source	No.	%	No.	%
Regional n=91	65	71.4	26	28.6
Offender n=32	25	78.1	7	21.9
Total	90		33	
Percent		73.2%		26.8%

Table VII shows the distribution of cases by race and sex. Black females are represented in a higher proportion of the cases than black males (22.2%) constituting well over a third (36.4%) of all girls and 37.5% of all blacks. White males predominate the total group constituting 75.5% of all males, 72.3% of all whites and 55.3% of the total group.

Table VII
Case Distribution by Race, Sex and Region
Children and Adolescents

	Male					Female					
Case Source / Race	Regional	Offender Advocate	Sex Total	Sex %	Race %	Regional	Offender Advocate	Sex Total	Sex %	Race Total	Race %
Black	12	8	20	22.2	62.5	10	2	12	36.4	32	37.5
White	52	16	68	75.5	72.3	15	5	20	60.6	88	22.7
Other	1	0	1	1.1		1	0	1	3.0	2	
Unknown	0	1	1	1.1		0	0	0		1	
Total	65	25	90	(73.2%)		26	7	33	(26.8%)	123	

Table VIII shows the racial and sex distribution of cases by type of handicap. Some interesting comparisons can be noted. Two-thirds of the boys are in the EH category as compared to slightly over one-half (54.5%) of the girls. There is a nearly perfect reversal between black and white girls with 40% white girls being MR/EH (60% EH) and 58.3% black girls MR/EH (41.7% EH). Among males the reversal is even more striking with 65% blacks being MR/EH as compared to only 23.5% of white males, and three-fourths white males being EH as compared to only a little over a third of blacks. Overall the racial distribution by type of handicap is considerably different with nearly 73% of whites categorized EH as compared to 37.5% of blacks.

Tables IX, X and XI show case distribution by age, race, sex, region and type of handicap. Examination of case distribution by age of clients shows about 62% of cases are adolescents aged 14 to 19 with another 24% aged 11 to 13. About 12% are in the 8 to 10 age group and less than 2% are less than 8 or over 19. Average age for all cases is 14.4; caseload breakdown for average age is shown below.

Table IX
Mean Age of Cases by Region

Region	Average Age
I	14.5
II	14.1
III	13.3
IV	13.8
Offender Advocate	15.6
All Cases	14.4

Offender cases are a somewhat older group of children with only 22% being under age 14 and none are under age 11, while 38 children or 42% of the non-offender cases (91) are under age 14 and 17.6% are under age 11.

One implication of this may be that a substantial number of potential offenses might be prevented if these children were properly served before adolescence.

There seems to be no major race differences by age group; that is a comparable percentage of each age range is present in both races.

Table VIII
Case Distribution of Race and Sex by Type of Handicap
Children and Adolescents

Sex	Male						Female						Total
	MR/EH		EH				MR/EH		EH				
Race	Number	Percent	Number	Percent	Male Total Number	Male Race Percent	Number	Percent	Number	Percent	Female Total Number	Female Race Percent	Race Total
Black	13	(65.0)	7	(35.0)	20	(62.5)	7	(58.3)	5	(41.7)	12	(37.5)	32
White	16	(23.5)	52	(76.5)	68	(77.2)	8	(40.0)	12	(60.0)	20	(22.7)	88
Other	0		1		1		0		1		1		2
Unknown	1		0		1		0		0		0		1
Handicap Total	30		60		90		15		18		33		
Percent	33.3		66.7				45.5		54.5				

Black MR/EH = 62.5%
Black EH = 37.5%

White MR/EH = 27.3%
White EH = 72.7%

Table X
Case Distribution by Age, Region and Type of Handicap
Children and Adolescents

	Regional Cases		Offender Advocate		Total		Age Group	
Age	MR/EH	EH	MR/EH	EH	MR/EH	EH	Total/Percent	
7-8	1	1	0	0	1	1	2	1.6%
8-10	4	10	0	0	4	10	14	11.4%
11-13	9	13	0	7	9	20	29	23.6%
14-16	9	19	4	6	13	25	38	30.9%
17-19	10	14	8	6	18	20	38	30.9%
20-21	0	1	0	1	0	2	2	1.6%
Sub-Total	33	58	12	20	45	78		
	36.3	63.7	37.5	62.5	36.5	63.4		
Total	91		32		123		123	

Table XI
Case Distribution by Age, Race and Sex

Age	7 - 8		8 - 10		11 - 13		14 - 16		17 - 19		20 - 21		Total	Total
Sex	M	F	M	F	M	F	M	F	M	F	M	F	Number	Percent
Race														
Black (Percent)	1 (3.1)	0	2 (12.5)	2	5 (21.9)	2	7 (34.4)	4	5 (28.1)	4	0	0	32	26.0
White (Percent)	1 (1.1)	0	8 (11.4)	2	17 (23.8)	4	21 (29.5)	5	20 (31.8)	8	1 (2.3)	1	88	71.5
Other	0	0	0	0	1	0	0	1	0	0	0	0	2	1.6
Unknown	0	0	0	0	0	0	0	0	1	0	0	0	1	0.8
Sex Total	2	0	10	4	23	6	28	10	26	12	1	1	123	
Age Total	2		14		29		38		38		2		123	
Age Percent	1.6		11.4		23.6		30.9		30.9		1.6			

History of Dangerous Behavior

A brief description of the EH behavioral characteristics was summarized from case records and judgment made as to whether there was a history of dangerous behavior. Dangerous behavior was defined in two categories:

violent: dangerous to self, and/or others as in attempted suicide, self-abuse or assaults on others, and
destructive: to property, i.e., setting fires, destroying property.

Cases were then tallied according to the types of behaviors exhibited. All but 15 cases (86%) were classified. Two-thirds of all classified cases had a history of violent and/or destructive behavior, with one-third (32.4%) considered not dangerous. Twenty percent were violent, 6.5% destructive and over 40% had histories of both violent and destructive incidents.

Of all the children who were dangerous, over 60% were both violent and destructive, 10% destructive only, and about 30% violent only. These results are reported in Table XII which also shows the frequency of cases with dangerous history by region and type of handicap.

Within the dangerous category, of the youngsters who were violent, 40 cases (54.8%) had incidents of self-destructive behavior, 57 cases (78.1%) had histories of assaultive behavior and 7 (10%) were property destructive, only. About 40% of the dangerous children had histories of all three types of behavior.

The Offender Advocate cases accounted for the highest percentage of dangerous children, 25 of 32 (78.1%) had exhibited violent and or destructive behavior. Cases from Region IV had the lowest percentage (37.5%). A higher percentage of MR/EH cases were dangerous, 72% as compared to 66% of EH classified cases. MR/EH children tended also to be less destructive of property and exhibit more violence toward others. The characteristic of dangerous history was also used in this study as a variable in examining other case aspects: foster services and abuse histories and will be reported later in the narrative.

Table XII
Cases Evidencing Dangerous Behavior by Region and Handicap

Behavior		Regional Cases n=82	Offender Cases n=26	Sub Total	Category Total and Percent of Dangerous Cases		Type - Total and Percent of Known Cases
Violent							
Self only	MR/EH	2	0	2	5		
	EH	3	0	3			
Self & others	MR/EH	3	0	3	7	21 (28.8)	21 (19.4%)
	EH	2	2	4			
Others only	MR/EH	2	2	4	9		
	EH	3	2	5			
Destructive to property	MR/EH	1	0	1	7	7 (9.6)	7 (6.5%)
	EH	3	3	6			
Violent & Destructive							
Others & property	MR/EH	3	2	5	10		45 (41.7%)
	EH	4	1	5			
Self & property	MR/EH	0	1	1	4	45 (61.6)	
	EH	1	2	2	3		
All SOP	MR/EH	10	2	12	31		1
	EH	11	8	19			
Dangerous Total		48 (58.5%)	25 (96.1%)				73 (67.6%)
Not Dangerous	MR/EH	11	0	11	35		35 (32.4%)
	EH	23	1	24			
Unknown	MR/EH	1	5	6	15		
	EH	8	1	9			
Total Cases		82	32		123		

Known Total		Total Non D	Dangerous Total	Violent	Destructive	V and D
39	MR/EH	11	28	9	1	18
	Percent	28.2	71.8	32.1	3.6	64.3
69	EH	24	45	12	6	27
	Percent	34.8	66.2	26.7	13.3	60.0
108		35	73	21	7	45

Risk of Correctional Placement

A measure of the seriousness of the dangerous behavior was sought by a judgment on whether the child was at risk for correctional placement. This judgment considered the behavior history, court involvement and whether or not charges were pending. Of the total group of cases for which this assessment was made (73 cases), slightly over half (56.1%) were considered at risk. Offender Advocate cases, however, accounted for the largest proportion. Thirty of the 32 Offender Advocate cases (93.7%) were considered to be in this category which constituted 73% of all at risk cases. These results are reported in Table XIII.

It should be noted, too, that all of the children exhibiting dangerous behaviors, and particularly those in the community, may be susceptible to criminal sanction, with perhaps the exception of the 5 cases with self-destructive histories only.

Table XIII
Risk of Correctional Placement

		Regional Cases	Offender Cases	Handicap Total	Percent	Known Case Total	Percent
NO	MR/EH	13	0	13	40.1	32	43.8
	EH	17	2	19	59.3		
YES	MR/EH	6	12	18	43.9	41	56.1
	EH	5	18	23	56.1		
				MR/EH	EH		
Total		41	32	31	42	73	59.3
Percent YES		26.8	93.7	58.1	54.7	56.1	
Unk.	MR/EH	14	0	14	28.0	50/123	40.7
	EH	36	0	36	72.0		

Custody

Table XIV reports the circumstances of custody of the case children by region and type of handicap. Since in about 18 percent of the cases, custody was not reported; the percentage distribution was thus calculated for known cases. About 60 percent of all children were in custody of their natural parents, 4 percent in a relative's custody and about 20 percent in the custody of DSS. Nine percent were in the custody of adoptive parents. Custody was joint between parents and DSS or DYS in 4 percent of the cases and was disputed in one case.

MR/EH children were much more likely to be in the custody of natural parents (58 percent) than were EH children (44 percent). They were also more likely to be in a relative's custody. EH children were more than twice as likely to be in the custody of DSS or to have been adopted.

Table XVI
Custody of Case Children and Adolescents

Legal Custody	Type of Handicap	Regional Cases	Offender Cases	Sub Total	Percent	Custody Total % of known cases
Natural Parents	MR/EH	20	6	26	57.8	60
	EH	25	9	34	43.6	(59.4)
	Percent	49.4	50.0			
Relative	MR/EH	1	2	3	6.7	4
	EH	1	0	1	1.2	(4.0)
DSS	MR/EH	4	0	4	8.9	19
	EH	11	4	15	19.2	(18.8)
DYS	MR/EH	0	1	1	2.2	2
	EH	0	1	1	1.3	(2.0)
OTHER						
Adoptive Parents	MR/EH	2	0	2	4.4	9
	EH	7	0	7	7.7	(2.0)
Self	MR/EH	0	0	0		2
	EH	0	2	2	2.6	(2.0)
Joint	MR/EH	0	2	2	4.4	3
NP/DSS	EH	0	1	1	1.3	(3.0)
NP/DYS	MR/EH	0	1	1	2.2	1
	EH	0	0	0	0	(1.0)
Disputed	MR/EH	0	0	0		1
DSS/DYS	EH	0	1	1	2.3	(1.0)
TOTAL		71	30	101		101
Unknown	MR/EH	6	0	6	13.3	22
	EH	14	2	16	20.5	(17.9)
	Total	91	32	123		

Foster Services History by Region and Handicap

Table XV reports the number and percent of children who have had a history of foster care services, including foster homes, emergency shelter services and group residential care. Forty-two percent of all cases for which this information was recorded had experienced foster care services. Twenty-five percent of cases in Region IV and 64% of Offender Advocate cases were in this category. A higher percentage of the EH children had experienced foster services: 49% of EH as compared to 35% of MR/EH.

Twenty-five of the 39 children (64.1%) with foster care history had four or more placements, and 30, about 77%, had experienced group residential care. Only 6 (15.4%) had one placement. Four children (10%) had experienced being held in jail. Clearly this group is characterized by impermanence and instability of home environment, being shifted from place to place numerous times.

The Offender caseload is particularly distinguished by this feature with 13 of the 16 children (81.2%) having experienced numerous placements, and 87.5% having resided in group facilities. Forty-one percent of all children who had foster care history (16 of 39) were in the Offender Advocate case group.

History of Abuse

A tally was also made of those children whose case records included notation of a history of abuse or suspected abuse and the type of abuse if known. Tables XVI and XVII report these results. This item was completed on 69 of the 123 (56.1%) case questionnaires. So in 44% of the cases, abuse history was not known. Of the known cases, 38% were known or strongly suspected to have experienced child abuse. Only 6% of these cases were suspected, thus one-third of the children were known cases of child abuse. Of the known cases of abuse, two-thirds (68.2%) were EH and one-third (31.8%) were MR/EH children. EH children were also more likely to be abuse victims: 37% as compared to 25% of MR/EH cases. Children in the Offender caseload constituted over half (54.5%) of all abused cases and 70% of the Offender case group had a history of abuse or suspected abuse.

Twice as many males had abuse histories than females, and all the cases of suspected abuse were male. Physical abuse was predominant: 16 of 22 cases, but 9 or 41% of the cases involved sexual abuse; 4 cases (18%) included both physical and sexual abuse. Of these nine cases, 5 were female and 4 were males. Three abuse cases occurred in correctional or treatment settings, one out-of-state.

The high rate of sexual abuse (40%) of these abused children and its equitable distrubution of between boys and girls, should be especially noted as it emphasizes their particular vulnerability.

Table XV
Foster Services History by Region and Handicap

		Regional Cases	Offender Cases	Handicap Total	%	Known Case Total	%
NO	MR/EH	19	3	22	40.7	54	58.1
	EH	26	6	32	59.3		
YES	MR/EH	5	7	12	30.7	39	41.9
	EH	18	9	27	69.2		
Known Total		68	25	MR/EH 34	EH 55	93/123	75.6
% YES		33.8	64.0	35.2	49.1		
Number of Placements				Total	%		
One		5	1	6	15.3		
2-3		6	2	8	20.5		
Numerous 4+		12	13	25	64.1		
Group Residence		16	14	30	76.9		
Adult Jail		1	3	4	10.2		
Unknown							
	MR/EH	9	2	11		30/123	24.4
	EH	14	5	19			

Table XVI
History of Abuse by Region and Handicap

		Regional Cases	Offender Cases	Handicap Total	Handicap %	Known Case Total	Known Case Percent
NO	MR/EH	16	3	19	44.2	43	62.3
	EH	21	3	24	55.8		
SUSPECTED							
	MR/EH	2	0	2	50.0	4	5.8
	EH	0	2	2	50.0		
YES	MR/EH	4	3	7	31.8	22	31.9
	EH	6	9	15	68.2		
				MR/EH	EH		Percent of All Cases
Total Known		39	20	28	41	69	56.1
Percent YES		25.6	60.0	25.0	36.6		
Unknown	MR/EH	11	6	17		54	43.9
	EH	31	6	37			

Table XVII
Abuse Cases by Sex and Type

	Physical	Sexual	Both	Strongly Suspected	Institutional
MALE n=15 (68.2%)	13	4	2	4	3
FEMALE n=7 (31.8%)	3	5	1	0	0
Type Total	16	9	4		
Case Total	13 (59.1%)	5 (22.7%)	4 (18.2%)	4	3

22

Dangerous Behavior, Abuse and Foster Care

A comparison of cases exhibiting dangerous behavior was made to determine the extent to which these children had experienced abuse and/or multiple foster care placements. Frequencies and percent distributions are shown in Table XVIII.

Of the 108 cases for which behavioral history was known, 73 (67.8%) had dangerous incidents. Thirty of the 38 children (79%) who had experienced foster care also exhibited dangerous behavior. This group constituted only about 40% of the dangerous cases however. When abuse history was similarly examined, 85% of children who had been abused also exhibited dangerous behavior, but abuse history accounted for only 30% of the dangerous cases. It should be noted from this rather limited comparison that while home instability and abuse are highly associated with dangerousness, the majority of dangerous cases in this study are not explained by these experiences. Additionally, 11 of the abuse cases have been in some type of foster care (42%) which conversely means that 29% of foster care children have a recorded history of abuse.

Table XVIII
Occurrences of Dangerous Behavior
with Foster Care and Abuse History

		Regional Cases	Offender Cases	Known Cases Total	
Cases with Dangerous Behavior	(Number)	48	25	73	n=108
	(Percent)	57.8%	96.1%	67.6%	
Total Cases with Foster Care History	(Number)	22	16	38	
FC with DB history	(Number)	19	11	30	
	(Percent FC)	86.4%	68.7%	78.9%	
	(Percent DB)	39.6%	44.0%	41.1%	
Total Abused and Suspected	(Number)	12	14	26	
Abused with DB history	(Number)	10	12	22	
Percent Abused with DB history		83.3%	85.7%	84.6%	
Percent of all with DB		20.8%	48.0%	30.1%	

Referral Sources

One hundred of the case questionnaires reported the source of referral to South Carolina Protection and Advocacy. Table XIX show that 48% of the referrals reported were by agency personnel, largely DSS; 37% were by parents, predominantly the mother and another 7% by relatives or friends of the family. Five percent were from legal sources: solicitor's office, guardian ad litem, private attorney and public defender. Agency referrals predominated in the Offender Advocate's cases and were in the majority in Region III, while parent referrals predominated in Regions I and II. Interestingly, schools were an infrequent source of referrals, (3%).

Table XIX
Source of Referral to SCP&A

Regions		I	II	III	IV	OA		%
Family/Friends								
Parent	Total	12	14	6	2	3	37	
	P	3	3	1	0	1	8	37.0
	M	8	11	5	2	2	26	
	F	1	0	0	0	0	1	
Relative		1	0	1	0	1	3	7.0
Friend		2	0	2	0	0	4	
Agency		6	11	8	2	22	49	
	DSS	5	7	3	1	10	26	
	School	0	1	0	1	1	3	
	DMR	0	1	2	0	0	3	
	DMH	0	0	2	0	1	3	49.0
DHEC-CC		0	0	1	0	0	1	
DD Case Coordination		0	2	0	0	2	4	
DYS-JPA		0	0	0	0	7	7	
D.C.		0	0	0	0	1	1	
DSS-P.		1	0	0	0	0	1	
Other								
Self		0	1	0	0	0	1	3.0
Anonymous		0	0	1	0	0	1	
M.D.		0	0	1	0	0	1	4.0
Solicitor's Office		0	0	0	0	2	2	
Private Attorney		0	0	0	0	1	1	
Public Defender		0	0	0	0	1	1	
Total		21	26	19	4	30	100	
Not Recorded		0	9	0	12	2	23	
Cases		21	35	19	16	32	123	

Are These Children Being Appropriately Served?

A main purpose of this analysis was to determine whether this group of EH and MR/EH children and teens were being served appropriately and ascertain, to the extent possible, their current service needs. Judgement by the case record examiner was made on the appropriateness of the services described in case records and in interviews with P&A staff familiar with the cases. Table XX reports these results. Cases in which the advocate questioned the appropriateness of the service circumstance, cases in which the service was recommended but delivery was uncertain or in which services were not being delivered are reported in the NO category. In 14 of the 123 cases, this judgement was not reported.

Well over one-third (38.5%) of these children were judged unserved or served inappropriately. A somewhat higher percentage of MR/EH children were considered inappropriately served, as were higher percentages of children in Regions I and III. The smallest percentage was in Region II.

Not surprising was the finding that 55% of those unappropriately served were in the Offender Advocate's case group. Seventy-five percent of that group were judged inappropriately served as compared to 24% of the other cases. This is a substantially high percentage of youngsters, and the following narrative will describe some of the basic characteristics of this unserved group prior to reporting the nature of the services being provided.

Tables XXI and XXII show the sex, race and age range of these children. The group is over 75% male with white males comprising about 55% of the total group. Compared to the appropriately served cases, this group has a somewhat higher percentage of boys (76 vs. 71%) and a substantially higher percentage of black children (36 vs. 22%) almost half of the black children (47%) fall in the inappropriately served group as compared to 31% of white children. The age distribution seems to compare dissimilarly to that of the served cases also, appearing a somewhat younger group with higher percentages in the 11-13 and 14-16 age ranges but the average age of this group is 14.1 mean age of the Offender Advocate cases is 14.7 and of the other cases is 13.5.

Table XXIII reports the level and type of handicap for these inappropriately served children and youth. They are clearly more likely to be multiply handicapped than the group judged as appropriately served. Twenty-four (57.1%) are mentally retarded as compared to the served group. Borderline and mild retardation levels account for nearly 60% of the group, with 20% moderate to severely retarded. Ninety percent of these children have at least one handicap in addition to their emotional handicap and almost half (47.6%) have three or more handicaps including EH. This is certainly a uniquely multi-handicapped group. Learning disability is a predominant handicap for 21.4% of the children. Epilepsy, uncontrolled seizures and neurological damage constitute equally prevalent handicaps with over 20% of the children having these disorders. Hyperkinesis is also highly prevalent. In comparison with the served cases, these children are more likely to be mentally retarded, to have epilepsy or neurological handicaps and a higher percentage are multiply handicapped (47.6%) than the appropriately served children (23.5%).

Table XX
Is This Child Currently Being Served Appropriately?

Case Source	YES Total YES	YES Case Source Percent	NO Total NO	NO Case Source Percent
Unknown n=14				
Region Total n=78	59 (88.1)	75.6	19	24.4
Region I (19)	11 (16.7)	57.9	8 (19.0)	42.1
Region II (27)	24 (35.8)	88.9	3 (7.1)	11.1
Region III (17)	12 (17.9)	70.6	5 (11.9)	29.4
Region IV (15)	12 (17.9)	80.0	3 (7.1)	20.0
Offender (31) n=109	8 (11.9)	25.8	23 (54.8)	74.2
All Cases Total	67	61.5	42	38.5
Percent				
MR/EH		59.1		40.9
EH		63.1		36.9

Table XXI
Sex and Race of Inappropriately Served Cases

n=42

Race		Black	White	Total	Percent	Served Percent
Sex						
Male	#	9	23	32	76.2	71.6
	%	(28.1)	(71.9)			
Female	#	6	4	10	23.8	28.3
	%	(60.0)	(40.0)			
Total	#	15	27	42		
	%	35.7	64.2			
Served	%	21.8	78.2			

Table XXII
Age Range of Inappropriately Served Cases

Age	Number	Percent	Served Percent	OA Cases	Others
7-8	0	-		0	0
8-10	3	7.1		0	3 (15.8)
11-13	10	23.8		5 (21.7)	5 (26.3)
14-16	18	42.8	38.0	10 (43.5)	8 (42.1)
17-19	11	26.2	38.0	8 (34.8)	3 (15.8)
20-21	0			0	0
Total	42			23	19

Table XXIII

Level and Type of Handicap of Inappropriately Served Children

n=42

Type	Total Number		Percent	Percent of Served Cases
Total Mental Retardation	24		57.1%	42.0%
		%		
Level-Unspecified	5	(20.8)		
Borderline	6	(25.0)		
Mild	8	(33.3)		
Moderate	4	(16.7)		
Severe/Profound	1	(4.2)		
Other				
Learning Disability	9		21.4%	18.5%
Epilepsy/Neurological/Seizures	9		21.4%	18.5%
Hyperkinesis	4		9.5%	17.3%
Speech	3		7.1%	12.3%
Autistic Tendencies	3		7.1%	3.7%
Visual/Hearing	2		4.8%	11.1%
Orthopedic	2		4.8%	1.2%
Severe Scarring	1		2.4%	0
EH only No other known	6		14.3%	48.1%

	Number	Percent	Served Percent
1 additional	38	90.5%	76.5%
Total - with three or more handicaps including EH	20	47.6%	23.5%

Other Characteristics and History

Tables XXIV through XXVII report characteristic histories of the cases designated inappropriately served as compared to the other served cases, in terms of custody, dangerous behavior, abuse and foster services.

Custody

Children in the inappropriately served group are less likely to be in the legal custody of their natural parents and more likely to be in agency or joint agency-parental custody.

Dangerous Behavior

These children are clearly the ones with histories of violent and destructive behaviors; only 7% of this group as compared to 44% of the served group can be termed non-dangerous. Over half of these children have had incidents of all three types of violent and destructive behavior: to self, others and property and 63% of the Offender group are in this most dangerous category. All (95%) but one of the inappropriately served Offender group have dangerous history. The one exception was classified as non-severe EH and his offense was chronic truancy.

Abuse History

Abuse history was known for 30 of the 42 inappropriately served cases, and over half (53%) had abuse or suspected abuse histories. This compares to 25% of the served cases.

Foster Services History

Similarly, nearly half of the inappropriately served group (49%) had experienced foster care or group home services, compared to 36% of served cases.

In summary, the inappropriately served child or teen is likely to be a white male, 14 years old, with multiple handicaps, having a history of abuse and numerous foster care and group residential placements, and exhibiting both violent and destructive behaviors. As has been shown, he has entered the service system at an early age, had encountered the court system and is likely to have been contacted by South Carolina Protection and Advocacy through its Offender Advocate Program.

Table XXIV
Characteristics of Inappropriately Served Cases
as Compared to Other Served Cases

n=42

Custody	Regional Cases	Offender Cases	Total	%	# Other Cases	# Other Known Cases
Natural Parent	13	9	22	53.6	38	63.3
Relative	2	1	3	7.3	1	1.7
DDS	3	5	8	19.5	11	18.3
DYS	0	2	2	4.9	0	0
Other						
DSS-DYS	0	1	1	2.4	0	0
NP-DYS	0	1	1	2.4	0	0
NP-DSS	0	2	2	4.9	1	1.7
Adopt P.	1	0	1	2.4	8	13.3
Self	0	1	1	2.4	1	1.7
Known Total	19	22	41		60	
Unknown	0	1	1	2.4	21	

Table XXV
History of Dangerous Behavior

Behavior	Regional Cases	Offender Cases	Total	Known Cases %	# Other Known Cases	%
Violent	5	4	9	21.4	12	16.7
Destructive	1	1	2	4.8	5	6.9
V and D	8	14	22	52.4	23	31.9
Not Dangerous	2	1	3	7.1	32	44.0
Known Total	16	10	36		72	
Unknown	3	3	6		9	

Table XXVI
Inappropriately Served Cases: History of Abuse

	Regional Cases	Offender Cases	Total	% Known Cases	# Other Known Cases	%
NO	8	6	14	46.7	29	74.4
YES	4	10	14	46.7	8	20.1
SUSPECT	0	2	2	6.7	2	5.1
Known Total	12	18	30	100.0	39	100.0
Unknown	7	5	12		42	

Table XXVII
Inappropriately Served Cases:
History of Foster Care Services

	Regional Cases	Offender Cases	Total	%	# Other Known Cases	% Other Known Cases
YES	6	12	18	48.6	20	35.7
NO	12	7	19	51.4	36	64.3
Known Total	18	19	37	100.0	56	100.0
Unknown	1	4	5		25	

Unmet Needs

Case records in the study were examined for indication of treatment recommendations not being implemented and are reported in Table XXVIII. The most frequent treatment recommendation was placement in a long-term residential treatment program for emotionally disturbed children or adolescents. This was the recommendation in 27 of the 42 inappropriately served cases (64.3%). Five of these case recommendations included 24-hour supervision and maximum security. Three recommendations were for non-correctional structured environments with consistent discipline.

The three case recommendations for long-term placements/adoption were youngsters with abuse histories who for various reasons were still residing in the abusive circumstances.

There were 3 recommendations for drug abuse treatment and 3 in which less restrictive environments (de-institutionalization) was recommended. In these latter cases, placements were being sought.

More appropriate educational services were recommended in 7 cases: one in which a summer program was needed, one IEP; three in need of more appropriate LD education and 4 in which their educational placement was questionable. Respite services, counseling and vocational training were other recommended services not being met.

Table XXVII
Unmet Needs

	Offender Advocate	Other	Total Number (Percent)
Long-term Residential Treatment Program for Emotionally Disturbed	19	8	27 (64.3%)
24-hour supervision/maximum security	5	0	5 (11.9%)
LEA unwilling/unable to fund	5	2	7 (16.7%)
Non-Correctional Structured Environment with Consistent Discipline	2	1	3 (7.1%)
Drug Abuse Treatment	3	0	3 (7.1%)
Protective Services Long-term Placement/Adoption	1	2	3 (7.1%)
Less Restrictive Environment	0	3	3 (7.1%)
More Appropriate Educational Services			7 (16.7%)
Appropriate Educational Placement		2	
Remedial not Special Education	1		1
Appropriate LD Services	2	1	3 (7.1%)
Appropriate EH services		1	1 (2.4%)
IEP	1		1 (2.4%)
Summer Program		1	1 (2.4%)
Respite Services		1	1 (2.4%)
Counseling	1	1	2 (4.8%)
Vocational Training	1		1 (2.4%)

Appendix B

JOINT LEGISLATIVE COMMITTEE ON

MENTAL HEALTH AND MENTAL RETARDATION,

SOUTH CAROLINA GENERAL ASSEMBLY

REPORT OF THE SUB-COMMITTEE TO STUDY MENTAL HEALTH PROBLEMS OF CHILDREN AND ADOLESCENTS

The sub-committee to Study Mental Health Problems of Children and Adolescents toured the following facilities:

Blanding House; Morris Village;
The Hall Institute;
S. C. Mental Health Program for Autistic Children in Columbia;
Richland County Mental Health Center and Bryan Hospital,
in preparation for meetings and recommendations to the full Committee on Mental Health and Mental Retardation.

FINDINGS OF FACT:

1. The first line of defense in mental health is at community mental health centers. There is only one child-adolescent psychiatrist in the South Carolina Community Mental Health System. Additional child and adolescent mental health professionals are needed. In addition, a strong linkage between school districts and mental health centers should be developed, closely monitored and maintained.

2. Children and adolescents should not be exposed to the general population of a psychiatric institution. Separate facilities should be the ultimate, but not too far off, goal in all future expansion plans.

3. For the child or adolescent who is unable to remain at home, hospitalization is the only alternative; even though it is often a more restrictive setting than the individual requires. It is the most costly setting.

4. To treat children and adolescents, the entire family often needs treatment; therefore, where removal from the home is required, the child should be located so that access for the family is convenient. There should be a very obvious attempt to encourage and continue to encourage regular visits.

5. No long-term community residential setting exists for the autistic child and adolescent. At present, the alternatives are institutionalization in a mental retardation or a mental health facility.

6. Bryan Hospital currently has an unused unit with a 36 bed capacity. The facility itself and the setting appear superior to Blanding House, which only has an average case load of 29 patients.

7. Approximately 40% of Bryan's usage is for emergency commitment patients who come from 29 counties. Transportation costs to and from local Probate Courts approaches one-half million dollars annually.

8. Due to the implementation of PL 94-142, school districts may be required to pay room and board for those children and adolescents who cannot remain at home and be educated within the public schools. At present school districts are having to send children to long-term residential schools out of state at a cost of $30,000 to $40,000 per child per year. No long-term residential school exists in South Carolina and as the various school districts are required to comply with PL 94-142, it would be more cost-effective for the State of South Carolina to develop a long-term residential school. Also, such a school would allow hospitals to be utilized for medical treatment and diagnosis, and hospital beds would not be tied up for long periods of time when another setting is more appropriate.

9. There is a shortage of staff at Blanding on weekends and evenings.

10. The construction cost per bed at the planned Children's Unit at Village B is in the neighborhood of $70,000 per bed.

RECOMMENDATIONS:

1. The Sub-Committee recommends that public hearings around the State or one large hearing be held with the full membership of the Mental Health/Mental Retardation Committee to receive in-put on mental health problems and needs of children and adolescents.

2. The Sub-Committee recommends that the program currently at Blanding House be moved to Bryan and that the General Assembly allocate and earmark sufficient funds to provide a minimal level of professional and support staff on evenings and weekends.

3. The Sub-Committee recommends that Senator Elizabeth Patterson's Sub-Committee look into the feasibility of individual hospitals in local areas providing temporary hospitalization for those requiring emergency commitment. This would free a number of South Carolina Department of Mental Health hospital beds, reducing the need for capital expenditures and provide for emergency mental health in-patient services at the local level, as well as allow the family to participate in the patient's treatment.

4. The Sub-Committee recommends that community treatment homes be immediately established as a less costly and less restrictive alternative to hospitalization.

5. The Sub-Committee recommends that community treatment homes be planned and implemented for autistic children and adolescents as an alternative to institutionalization.

6. The Sub-Committee recommends that specific programs and staffing be required in all community mental health centers directed toward children and adolescents, including specific programs providing linkage with public school districts. The Department should also establish adequate staffing and program requirement for children and adolescents.

7. The Sub-Committee recommends that a long-term residential school be planned and implemented as an alternative to hospitalization and as an alternative to school districts having to send children out of state for long-term residential schooling.

8. The Sub-Committee recommends the first priorities for emotionally handicapped children and adolescents in South Carolina are:

a. community treatment homes

b. adequate children and adolescent programs at Community Mental Health Centers

c. residential school treatment program.

Respectfully submitted,

Senator Hyman Rubin
Rep. Melvin E. Nunnery, Chairman
Senator Elizabeth J. Patterson
Louise Ravenel
Steve Glass

RESOLUTIONS

The following resolutions were passed by the members of the subcommittee on Mental Health Services for Children and Adolescents, Representative Ernie Nunnery, Chairman, and the subcommittee to Study Emergency Mental Health Services, Senator Elizabeth J. Patterson, Chairman.

"We wish to express to the members of the Mental Health and Mental Retardation Committee that any cuts that are made in the budget of the Department of Mental Health at Crafts Farrow Hospital and State Hospital be made at the administrative level and not at the driect services level."

"We wish to see all 'patient fee' account monies spent only for the Department of Mental Health and within the Department only for community mental health centers."

Elizabeth J. Patterson Melvin Ernest Nunnery

For the Subcommittees

Appendix C

DIVISION OF MENTAL HEALTH, MENTAL

RETARDATION AND SUBSTANCE ABUSE SERVICES

325 NORTH SALISBURY ST.

RALEIGH, N. C. 27611

WILLIE M. PROGRAM PLAN

PART I

NARRATIVE DESCRIPTION

I. POPULATION TO BE SERVED

The proposed system of services is planned to meet the needs of emotionally disturbed, mentally or neurologically handicapped children and youth whose violent or assaultive behavior leads to their exclusion and/or extrusion from currently existing treatment programs. Their behavior problems are serious and chronic. Virtually all of them come from troubled, dysfunctional families with social histories which often include alcohol related and court related problems, suspected or known child abuse or neglect, and other forms of family violence. Many have experienced a series of unsuccessful foster home placements and treatment programs. The failure of these placements appears to be due to: 1) inadequate support services, 2) the lack of linkages, that is the lack of planned, coordinated movement through the various services or service systems; and 3) an absence of appropriately restrictive and intensive services.

The Department of Human Resources expects that over the next several months approximately 1000 residents of the State will be identified as members of the Willie M. et. al. class. The actual numbers who will be confirmed as class members will depend upon two circumstances: 1) the obtaining of parental consent to be considered for the class; 2) the results of thorough diagnostic testing indicating that the child meets the class definition.

The identification of class members is an ongoing responsibility; thus as children are identified, there will be variation in the size of the class.

Narrative Description (cont.)

II. ASSUMPTIONS

A. A system of services ranging from highly restrictive settings to settings which are preparatory for normal living is needed to rehabilitate these individuals and to prevent the "revolving door syndrome."

B. The system must provide for linkages among the various components within the system as well as services from other systems. Clearly no one system of care can provide for all the needs of these children and there must be coordinated efforts between human service providers (public and private), educational systems and courts.

C. Graduates of intensive, and restrictive (expensive) programs frequently fail after discharge when they are released into their communities to "sink or swim" without supportive services. Often programs react to this phenomenon by retaining children overly long because no less restrictive and more normal setting is available to meet the child's needs. This reaction creates a "bottle neck" phenomenon which prohibits timely movement by the client to a less restrictive setting as a part of his reintegration into the community. Other programs discharge the child prematurely, thereby incurring a high rate of recidivism. A well designed system of services must embody the needs of these children for gradual promotion through less and less restrictive service settings. To deal effectively with these children, the full continuum of care must be in place; discrete components, whether of the more intensive or the less intensive variety, standing alone, will fail.

D. Children are best served as close to their own communities as possible for reasons ranging from the increased likelihood of family involvement in the rehabilitation or treatment plan to the enhancement of the service system's ability to reintegrate the child gradually into his school, family and other element of his natural environment. However, until such services are fully developed, services for the regional psychiatric hospitals will continue to be needed for certain children. (See III.D.)

E. Area mental health programs have the ultimate case management responsibility for catchment area residents, so that whenever possible, resources should be allocated to them to enable them to provide appropriate services directly or through contracted services.

F. Individualized treatment planning including case management is essential to the success of a system of care.

Narrative Description (cont.)

III. A PROPOSED SYSTEM OF SERVICES

A. THE ZONE CONCEPT

This plan proposes to establish sub-regional zones of approximately equivalent population (see attached map) by grouping geographically proximate area programs together. Each zone will offer a full continuum of services to its target population. Not all services will be necessary in all catchment areas, but the full continuum of services will be accessible to all catchment areas through the sharing of resources. The system of services will use existing community services as possible and appropriate. The funding request attached is for new residential and non-residential services and for needed increased capacity in certain existing services.

B. CASE MANAGEMENT

Case management is an essential element in the successful functioning of the continuum of care. Case management is planning and directing the provision of services to a child and his/her family or custodian who are receiving or who are applying to receive services. Activities include initial and on-going assessment of the nature, impact and extent of their current service needs as well as establishment of ways and means to address the presenting problems. This includes keeping track of what has been provided and what can be provided in relation to the client's needs and the related needs of his/her family or custodian(s). Activities include determination of methods of service delivery which will best support resolution of the child's and family's or custodian's problem(s) and effectively facilitate achievement of the agreed upon goals. This means assuming the role of primary agent who assures an equitable, consistent, dependable and coordinated flow of services to the client and family or custodian as they move through the service delivery system. Activities include establishing separate and joint responsibilities, authorities and tasks among services workers, services agencies and the family or custodian who are involved in the process of helping the child. Such a coordinated delivery system allows a continuing analysis of program needs.

C. METHOD OF RESOURCE ALLOCATION

Whenever one type of service is underutilized or overutilized, a method should exist to shift resources into another indicated type of service. The system must allow for flexibility in the adjustment of funds within and across levels of care in the continuum of service delivery so that area programs can "fine tune" and reorganize service patterns to stress appropriate continuity of service. Unified management of the public mental health resources within a region or zone permits jointly planned resource sharing in terms of changing needs.

D. ROLE OF THE REGIONAL PSYCHIATRIC HOSPITAL

The small children and youth units within each regional hospital remain a needed part of the continuum of care for those North Carolina children with the most complex and severe emotional and behavioral problems. Services at this level must be accessible both for certain "Willie M. type" children and for other severely disturbed children. The regional hospitals should continue to fulfill the following functions in the continuum of care for Willie M. type and other children.

1. Short Term Units:

   a. Offer a small number of behavior management beds as back-up to the community-based programs to provide short term crisis stabilization.

   b. Offer intensive inpatient diagnostic evaluations (typically short term) to facilitate the development of treatment plans for those children with the most complicated problems.

   c. Offer apprenticeships and other training experiences to community-based program staff in techniques and procedures for treatment of "Willie M. type" children and other seriously emotionally disturbed children.

   d. Provide sites for training of mental health professionals in university-based speciality training-psychiatrists, psychologists, social workers and special educators.

2. Long Term Units:

   a. Offer long term hospitalization to psychotic, borderline psychotic and other extremely, seriously disturbed children who require inpatient treatment of an intensive and specialized nature.

   b. Offer apprenticeships and other training experiences to community based program staff in techniques and procedures for treatment of "Willie M. type" children and other seriously emotionally disturbed children.

   c. Provide sites for training of mental health professionals in university-based speciality training-psychiatrists, psychologists, social workers and special educators.

E. SERVICE GAPS REMAINING

This proposal requests funding to meet only a portion of the needs projected for the Willie M. Class. The proposal encompasses a funding request for services which can be realistically implemented during the FY 1981-83 biennium. As the service system matures and the Willie M. Class becomes clearly defined, the system can be "fine tuned." Remaining service gaps can then be more efficiently identified and additional resource needs more accurately requested, which can be met either be reallocation of underutilized services or additional funding.

PART II

PROGRAM COMPONENTS

WM01 Case Management Services

This service component provides planning and direction for the provision of services to a child and his/her family or custodian. Activities include assessment of client needs, planning for services to address those needs, linking and coordinating the flow of services to the client, monitoring the services provided to the client, and adovcating for the client.

WM02 Respite Services

The component provides services for the families of mentally retarded or emotionally distrubed children who need periodic relief from the constant and often stressful care of the child. Services may be provided either on a planned or emergency basis. While in respite care, the child receives supervised care with the provision for meeting the child's basic health, nutritional, and daily living needs. Respite may be provided in a variety of models including center based services which affords the opportunity for continuous care for up to 30 days; contracted services with citizens for use of their home for provision of respite; and availability of companion sitters who can provide respite services in the home of the child.

WM03 Crisis Stabilization/Residental (Short-term)

This component provides a temporary supervised residential environment to children in crisis situations who need temporary residential alternatives and assistance until the crisis is stabilized or a longer term plan can be developed. Children in crisis who do not need the full range of medical staff and facilities as provided in inpatient services are appropriate for this type of care, although medical backup will be available.

WM04 Alternative Family Living: Specialized Foster Care

Children served in this component are placed individually or with one other child in community foster care homes with specially trained and supported foster parents. Foster parents receive a monthly subsidy for services to meet the special needs of these children. Professional mental retardation or mental health workers provide backup training, case management and treatment services.

WM05 Alternative Family Living: Supervised Independent Living for Older Children

Older adolescents (ages 16-18) using this service live with a highly trained alternative parent or supervisor in a home or apartment setting. Activities include parental care or supervision, emotional, physical, and cognitive development, social integration, pre-vocational skill-building, and either work with the parents to reintegrate children into their families or work toward independent living.

WM06 Alternative Family Living: Intensive Service

Children served in this component are placed individually in community homes, with specially trained and supported professional level foster parents. Training for these parents is more intensive and care-specific than in current specialized foster care models and the parents are actively and regularly involved in providing direct treatment efforts for the youth. Support systems and case management services for these special families are also intensive and youth in their placements are likely to be simultaneously involved in many other services.

WM07 Residential Group Living: Moderate Supervision

This model offers residential treatment to children with moderate to severe problems and includes multiply-handicapped children. These are children for whom removal from home is essential to facilitate treatment. Children in this setting will generally attend public school but may use day treatment or have a job placement while in residence. These group homes provide healthy adult role models, group, individual and family counseling as appropriate, liaison services to mobilize community and family resources, and social, emotional and cognitive training. Staffing is sufficient to supply a moderate level of supervision. Length of stay will typically be 6-8 months but may be longer dependent upon a child's individual needs.

WM08 Residential Group Living: Extensive Supervision

This model offers highly structured residential treatment to children with moderate to severe problems including multiply-handicapped children. These are children for whom removal from home is essential to facilitate treatment. Children in this setting may use day treatment or have a job placement. Some may be able to attend public school; for others, special education services may need to be offered at time within the residential or day treatment setting. These group homes provide healthy adult role models, group, individual and family counseling as appropriate, liaison services to mobilize community and family resources, and social, emotional and cognitive training. Staffing is sufficient to supply an extensive level of supervision including control of most aggressive behaviors. Facility may be locked if needed. Length of stay will be up to 2½ years according to the child's individual needs.

WM09 Residential Group Living: Extensive Supervision-High Management

This model offers highly structured and secure residential treatment to children with severe emotional or behavioral disturbance including multiply-handicapped children. These are generally agressive children for whom a secure (generally locked) environment is essential to facilitate treatment.

These children are too disturbed to attend public school or vocational training, but they may attend a day treatment program. These homes provide healthy adult role models, group, individual, and family counseling as appropriate, liaison services to mobilize community and family resources, and social, emotional and cognitive training. Services such as emergency services, educational or vocational training, day treatment and counseling may be provided by the program, from other mental health center components or from another agency as indicated. Staffing patterns using the shift system or modified shift system may be used, but in general, a "home-like" atmosphere is maintained. Re-education models or other models are used to provide this service.

WM10 Residential Group Living: Intensive Treatment (Non-Medical) - High Management

This model offers highly structured and secure residential treatment to children with severe emotional or behavioral disturbance including multiply-handicapped children. These children are highly aggressive and require a secure (generally locked) environment. These children are too disturbed to attend public school or vocational training. Full services are generally provided within the setting, but in some instances, the children may receive services in another setting (e.g., day treatment). Emphasis is placed on containing and controlling the child's violent and aggressive behavior and establishing positive, appropriate behavior to replace negative destructive behavior. As soon as the child's behavior is under programmatic control, he/she is moved to a less restrictive setting. Length of stay is usually short-term. Activities emphasize social skills, emotional and cognitive development, daily living skills, vocational skills and recreational skills. Liaison services are provided to community and family. The staffing pattern utilized is a shift system employing paraprofessionals, teachers and therapists.

WM11 Specialized Group Living

This model of service provides residential services for children who have extensive developmental, medical and behavioral problems. Individualized programming is provided in the facility through an interdisciplinary staff, which provides contant supervision and a high degree of programmatic structure. Often children served by these programs are too multiply handicapped to be appropriately served in the public school classroom.

WM12 Transitional Group Living

This model of residential services provides time limited behavioral/developmental programming for children who have moderate to extensive skill deficits and behavior problems. Intensive prescriptive behavioral programming is provided in order that the child may return to residence with his own family or other less restrictive living environment.

WM13 Summer Programs for School Children

This component serves school-age children with mental health or mental retardation problems who need summer programs to meet their individual needs and the needs

of their families. These children may include those whose difficulties cause them to be "high risk" for court involvement during unstructured summer months and whose needs are not met in other generic summer programs (youth camps, etc.). Activities in these programs occur in a variety of settings, including developmental day centers, community recreational resources and day camps. These services are supervised by individuals who are knowledgeable about emotionally disturbed children or mentally retarded children. The services include child care, group socialization experiences, and recreation.

WM14 Preschool Developmental Day

This component serves children with mild/moderate/ and severe developmental deficits in an organized and licensed day center setting. Services are available five days per week for a minimum of eight hours per day. Individualized programming is provided for the child in the skill areas of cognition, self-help, motor, speech and socialization. Additionally, family support programs are incorporated in the service. A staff child ratio of 1:5 is required; however, a ratio of 1:3 is recommended.

WM15 Day Treatment (Partial Hospitalization): Moderate Services

This component serves children with moderate to severe problems. Children who have difficulty participating in partial or full day public school programs because of the severity of their problems are appropriately served in this setting as are children who require intensive intervention to prevent hospitalization. Day treatment services may often be provided in conjunction with residential treatment services. Day treatment planning, recreation, social skills development, group counseling, services to parents and client advocacy.

Other services may include individual therapy and educational or vocational training and case management. Services are generally provided four hours per day, two to five days per week. The staff client ratio must be at least at the 1:4 level of intensity.

WM16 Day Treatment (Partial Hospitalization): Intensive Services

This component serves children with severe problems. Children served in this component are often violent and assaultive. They require an intensive staffing level (staff: client ratio of at least 1:2) to enable the control and remediation of these children's problems. Services are often provided in conjunction with residential treatment. Full educational/vocational services are generally provided within the setting. Other services provided include diagnosis and treatment planning, recreation, social skills development, group counseling, services to parents, and client advocacy. Case management and individual therapy may also be provided. The services are generally provided four to eight hours per day, five days per week.

WM17 Emergency Clinical Services

These services are provided for children in acute crisis who require immediate mental helath evaluation and treatment. The service setting is non-residential. Contact may be initiated in person or by telephone at any time. Face-to-face contact with a mental health professional is arranged if necessary. Based on the initial evaluation, preliminary diagnosis is established and treatment with referral, follow-up, and case management as needed is provided.

WM18 Outpatient Treatment Services for Child

This component serves children with mild to moderate problems who can otherwise function in their natural environment. In some instances, this service may also be used for children with moderate to severe problems in conjunction with other services of a more intensive nature (e.g., partial hospitalization, alternative family living, residential group living). Outpatient treatment services include screening, evaluation, diagnosis, treatment, follow-up, work with families, case consultation to schools, courts, DSS, and other service providers, and case management.

WM19 Family Support Services - Outpatient or In Home

This component of service includes family counseling; individual counseling for family members; parent training and information; parent support groups; and subsidy for maintenance of the child in his own home. Combinations of these services may be made available to the parents, siblings and extended family members of children with varying levels of disturbance and who are participating in any specialized treatment program. The purpose of such services is to improve or stabilize the family living environment of the child; to minimize the necessity for out of home placement of the child; to assist parent and family members to better understand the effects of the child's disabilities; and to assist parents in better affecting their child's developmental growth.

WM20 Transportation Services

This component provides transportation services to those clients in need of such services in order to participate in the needed programs or services. It includes transportation coordination, the training of clients in the use of public transportation, the provision of segregated transportation when appropriate, and assistance with carpooling and planning.

WM21 Wright School

WM22 Adolescent Re-Ed (NCSCFRC-Butner)

WM23 Inpatient Hospitalization -- Short-term/Crisis

This service is appropriate for children with severe emotional or behavioral disturbances who cannot be served appropriately in a less restrictive setting. Services include a) psychological and medical diagnostic procedures; b) observation treatment modalities including medication psychotherapy, group therapy, occupational therapy, industrial therapy, vocational rehabilitation, recreation therapy and milieu treatment; c) medical care and treatment as needed; d) supportive services; e) room and board. Both voluntary and involuntary clients may be served in this setting.

This service is based on the likelihood of stabilization within a short period of time and transfer to a less restrictive setting for continued treatment.

WM24 Inpatient Hospitalization - Long-term

This service is appropriate for children with severe emotional or behavioral disturbances who cannot be served appropriately in a less restrictive setting. Services include a) psychological and medical diagnostic procedures; b) observation treatment modalities including medication psychotherapy, group therapy, occupational therapy, industrial therapy, vocational rehabilitation, recreation therapy and milieu treatment; c) medical care and treatment as needed; d) supportive services; e) room and board. Both voluntary and involuntary clients may be served in this setting.

This service is for children with especially intractable problems who require intensive inpatient treatment to achieve stabilization and/or problem remediation. Length of treatment will typically be more than one year.

WM25 Mental Retardation Center

WM26 Wilderness Camp (Short-term)

This component serves children 6-18 who have mild, moderate, or serious problems. Services provided include supervised recreational and educational experiences with supervised peer interaction and the provision of healthy adult role models. The service is provided during weekends through the year or 6-9 weeks in the summer and includes outdoor living experiences to help the client develop coping skills and behavior control as well as academic and vocational skills. Liaison services are also provided to promote community and family interaction.

WM27 Wilderness Camp (Long-term)

This component serves children 6-18 who have moderate to severe problems, whereby removal from the home is essential to facilitate treatment. Services are provided in an emotionally healthy, structured, therapeutic environment in groups of 10 or less. Healthy adult role models provide supervision of school activities, peer interactions, and everyday living activities. Other services include recreation, group counseling to clients and parents, and client advocacy. Through outdoor living on a long-term basis (9-15 months) the child is helped to develop coping skills, self-esteem, and academic or vocational skills. Liaison services are also provided to promote community and family interaction.

WM28 Training School

WM29 Educational Services Provided by Public School at Mental Health Program Site (day)

WM30 Educational Services Provided in Public School

WM31 Foster Care

This is a legally defined service provided by a county DSS or by a private provider so licensed. This service is a legal substitute for care and child rearing provided by the child's parent(s) or other relatives.

WM32 Probation

This is a legally defined service of supervision, prescribed by the court in relation to charges brought against a juvenile.

WM33 Before and After School Program

This component provides services for school aged children who need care and intervention services before and after school hours to meet their individual needs or their families' needs. Services incorporate individualized programming in the developmental skill areas and are provided in a licensed day care setting. Staff who are professionally qualified are required by standards.

WM34 Assessment/Prescriptive Services

This component provides periodic services to individuals in need of diagnostic evaluation, behavior assessment, and behavioral programming and to individuals who are being screened for services or who are in an on-going service program.

WM35 Advocacy Services

This component provides advocacy services (friendship and emotional support, assurance of quality services, that rights are met, and freedom from abuse) to all individuals in need of such services. It includes the coordination, recruitment, and training of advocates as well as the assessment of client needs for advocacy and the appropriate matching of the volunteer advocate with an individual and his/her needs.

WM36 Detention

"Confinement of a juvenile pursuant to an order for secure custody pending an adjudicatory or dispositional hearing or admission to a placement with the Division of Youth Services."

WM37 Vocational Placement

A supervised experience in work related activities in preparation for later independent employment.

WM38 Other (Specify)

WAKE COUNTY JUVENILE TREATMENT SYSTEM

401 EAST WHITAKER MILL RD.

RALEIGH, N. C. 27608

WAKE JUVENILE SYSTEM

Presentation by Dr. Don Taylor to Technical Assistance Session held December 2, 1981 in Tallahassee, Florida on "Managing Cases of Dually Diagnosed MR/DD Clients," sponsored by The National Association of State Mental Retardation Program Directors, Inc. in cooperation with Florida Developmental Services Program Office.

Dr. Don Taylor, Director of the Wake Juvenile System located in Raleigh, North Carolina, began the session by explaining how the Wake System came into being, its purpose, and how it operates. Wake County, which includes the City of Raleigh, has a population in excess of 250,000, and is located near four state institutions -- two for the mentally ill (Dorthea Dix and John Umstead) and two for the mentally retarded (Murdock Center and Caswell Center). The County has been over-represented in the population in state hospitals, a number of these individuals had dual MH/MR diagnoses.

Several years ago the County authorized the use of community demonstration funds to develop a mentally retarded/behaviorally disordered program called Stonehouse. This population was seen as having the greatest risk of placement in a psychiatric facility. Intially, Stonehouse focused on mildly/moderately retarded children and youth who had severe behavior problems.

A group home was established to serve five residents, all of whom were very aggressive. A very rich staffing pattern was needed to provide adequate supervision and training. Thus, they chose to have shift workers, rather than full-time live-in staff. There are two persons on duty at all times with a swing person for emergencies. Dr. Taylor indicated that he feels this type of staffing also helps with the problem of staff burnout.

The program was committed to involving the residents in community programs whenever possible; this included enrollment in public schools and existing sheltered workshops/activity centers. It took a year to achieve this goal, but now all the residents attend community programs. During the year it took to gain community cooperation, the vast majority of services were

provided by special education staff located in the facility. These same staff now serve as outreach workers.

Dr. Taylor went on to point out some interesting facts about the program:

--- No one has ever had to be ejected from the program.
--- 80% of the population has a history of prior institutionalization.
--- The majority of the referral are males between the ages of 14 and 21 years.
--- The program is coed, with usually three males to two females.

Once all the group home residents were enrolled in community programs, the staff hired for that purpose was able to spin-off a new component -- outreach. A decision was made to keep the active waiting list of 20 persons and to have the outreach staff work with these 20 individuals while they were still at home. In addition, when a client returns to the community, an outreach worker provides a minimum of two weeks of on-site services. This has facilitated the acceptance of clients previously seen as too difficult to manage. Needless to say, one of the biggest problems the Wake System staff have is convincing the people who had sought Stonehouse placement for the clients, that the goals had indeed been met and the clients were ready to be returned to the community. Their reputations have preceded them and programs were reluctant to accept them back again.

The Wake Juvenile System, according to Dr. Taylor, is an example of a community mental health program operating a community-based mental retardation program using state dollars. The success of the Stonehouse group home resulted in the county's willingness to work with other multiply diagnosed mentally retarded persons.

A law suit, Willie M. et al vs. James B. Hunt, Jr. et al was the catalyst for expanding services to the juvenile delinquent, the acting out, emotionally disturbed mentally retarded adolescent.

The Willie M. lawsuit (as it is called) was filed following one of the Judge's (who had been regularly hearing cases involving mentally ill, mentally retarded, neurologically impaired children) invitation to a number of defense lawyers, to sue him. (This judge is named as one of the defendants.) It had become apparent to this judge, as he kept seeing the same defendants with the same presenting problem, that a large number of disturbed individuals who were entitled to services, were not receiving them. This was particularly true if their diagnosis included aggressive behavior. Neither the community nor the institution was willing/able to serve this population. It should be noted that the state capitulated in the lawsuit, after hearing the testimony of only two judges who presented unshakable data regarding the number of children who had been presented to the court -- specifically, the diagnoses of the children and the frequency of their appearances in court.

Part of the court settlement reached by all parties states that community programs had to be tried before institutional placement was sought. The plaintiff class numbers about 1,000 persons throughout the state. Thus the state was faced with a substantial number of individuals in need of services.

Wake County became one of the first counties to implement the settlement. The county decided that it would be better to deal with the problem in a planned systems approach manner rather than on a facility by facility basis.

Dr. Taylor explained that the Wake System began with a secure facility which involved converting a detention home into a secure treatment facility with a capacity for 14 residents. The facility is now dually licensed as both a detention facility and a secure treatment facility. This secure facility may serve as the point of entry into the system, however, it does not have to be the point of entry. The secure treatment center also serves as a back-up to the less secure facilities in the system.

The usual length of stay is 90 days during which time a diagnostic work-up is done, a family assessment is conducted, and a treatment plan is written.

In addition to the secure treatment center which is necessarily well-staffed and supervised around the clock, there are also community-based group homes that fall into the category of (1) high management or (2) moderate supervision. In the high management group homes, there is staff available around the clock in 10 and 12 hour shift patterns. This means that there are two persons on duty for twelve hours each (7 p.m. to 7 a.m.). Two persons form 7 a.m. to 10 a.m.; (one of which is on from 7 a.m. to 7 p.m., one is part-time 7 a.m. to 10 a.m.); one person 10 a.m. to 4 p.m. (the person who is on from 7 a.m. to 7 p.m.); and two persons from 4 p.m. to 7 p.m. (1 full time, plus one part time). There are currently two such facilities in Wake County.

The next level, moderate supervision, has a leaner staff/client ratio and less intense program structure. The county contracts for this service with private non-profit organizations that are providing residential services in the county. The staffing pattern depends upon the individual provider as well as the needs of the residents. Back-up staff and crisis intervention is provided through the Wake Juvenile System on an as needed basis.

Dr. Taylor indicated that he felt one of the reasons the system has been so successful is that the Wake County officials, spent a lot of time convincing the Judges to make a voluntary commitment of a juvenile to a "continuum" rather than just to a particular facility. This breakthrough has allowed the staff to move the client along the system without having to constantly have additional court hearings. In fact, some juveniles never have to leave their natural homes--outreach workers go into the home and do the necessary training. There is, however, a re-hearing before the judge every 90 days at which the individual is represented by an attorney.

This re-hearing provides the assurances that active programming is going on and updates the Court on progress being made.

In addition to the nine community-based group homes, there are three specialized foster care homes for multiply handicapped younger children, and one supervised apartment, operated by a private non-profit agency for older adolescents (20 years of age).

The three foster care homes are another example of multi-agency cooperation. The Department of Social Services provides the base rate of $340 per month, which is then increased by another $100 from the Department of Mental Health. DSS is responsible for licensure and recruitment, while DMH provides staff training and support. Dr. Taylor noted that recruitment of foster care families has been somewhat of a problem and that the present foster care families have been the most successful recruiters. The three foster care families meet as a group with Wake Juvenile System staff at least twice a month.

The system described above is expected to serve about 60 individuals at its peak.

A description of the supports provided to the residential programs and the clients, was then given by Dr. Taylor. Each client has a treatment team that plans the total program and manages all aspects of the case. The program did not want to separate case management and treatment. The team members vary according to the individual needs/programs of each client. One person on the treatment team is designated the primary case manager and sits in on all team meetings and follows the client as he/she moves through the system. There are currently three different teams: 1 team deals with the 10-11 persons in the secure center and meets once a week; one team works with the clients in either the high management or moderate supervision group homes and meets once a week; and one team serves as an outreach treatment team to the specialized foster care homes and those clients still residing in natural homes who are receiving support from the outreach workers (of which there are three).

As mentioned earlier in reference to the first Wake County group home for behaviorally disturbed (Sonehouse), the outreach workers have been one of the most effective elements of the system. They have been able to serve a number clients with very unique problems. The fully integrated system became active in April of 1981, so while the track record is of short duration, the successes to date have been great.

Other supports provided to the program from outside the Wake Juvenile System were next discussed by Dr. Taylor. Day treatment/educational services are currently being provided to sixteen clients through a program jointly operated by the County Educational system and DMH. While the program is housed in a building that is not part of a school, the clients have ready access to community recreational and school facilities. The staff is comprised of two teachers and two aides funded by the school system; ½ clinical psychologist supported by DMH; and two recreational staff, who also do counseling, financed by the Wake Juvenile System.

The court counselors have been another important source of support. They have worked closely with staff in the areas of client selection family counseling/training, public school placement, escort services (e.g., to medical appointments), etc.

Many of the services provided by the court counselors are also provided by DSS workers. This seeming overlap helps to insure that most, if not all, clients receive a full range of needed services. Furthermore, almost one-half of the clients are on the DSS roles.

Outpatient services, including individual and group therapy as well as family therapy (almost all of the families have participated in therapy) have been provided free of cost by the mental health center. According to Dr. Taylor, discussions are underway regarding implementing third party payments.

Clients have used existing community recreational programs and plans are being made for attending the summer camp program run by the County.

Vocational training has not been used very much to date. There have been some efforts made to locate jobs for older clients moving into the group home component of the system. In some cases they have three different individuals working one job in order to keep that job available. Obviously, this is not always going to be a satisfactory arrangement and more vocational training opportunities and placements are going to have to be developed.

Separate from the Wake Juvenile System, but still under contract with the Mental Health program, exists an Advocacy and Management System comprised of lawyers and private citizens whose job is to keep an eye on the legal aspects of the program. The attorneys manage to see every child in the system, once every two weeks, in a face to face encounter.

Dr. Taylor then provided the group with further information on the 1,000 identified class members. The class is open-ended, this means that any community agency in the state can identify individuals for inclusion in the class. Referrals are made to local Mental Health Agencies which then obtain parental/guardian consent for evaluation and collection of relevant materials. Mental Health takes the lead in assuring that all tests/evaluations are completed and all other data are collected and forwarded to the State Certification Committee, which has been established to review all referrals and make the determination regarding class membership. The Certification Committee has a psychiatrist, a clinical psychologist, and a special education specialist. At least two members must certify a child before he/she can be included in the class. The Committee is looking for: (1) evidence of mental retardation or emotional illness; and (2) history of assaultive behavior which must be documented in terms of frequency criteria and severity criteria.

Furthermore, there is a Federal Court Panel overseeing the suit which has the option of reviewing any de-certified or uncertified cases. So far, this panel has exercised this option in all applicable cases. Approximately one-half of all the cases they have reviewed have been sent back to the Certification Committee.

One criteria for exclusion from the class is if the person is already placed in an appropriate program. There must, however, be a description of what the next step in his/her treatment will be and the availability of the next step.

Some demographic features of the class were then presented. About 60% are borderline or mildly retarded, a significant number are moderately retarded, with only a very few being severely/profoundly retarded. The youngest served in the community was five years of age, the youngest served at the Wake group home was 8 years old. There is a very high frequency of males between the ages of eight and eleven who are very very aggressive.

The treatment received by the clients is highly individualized. Every child has an individual therapist, twenty-eight clients are participating in group sessions as well. Some are in peer counseling, others are in a community training group which resembles an assertiveness training process but which is geared to helping the juvenile to better deal with frustration and not let things build up to the point of losing control. Early and appropriate expressions of anger and frustration are being encouraged.

The staff is specially trained to handle the aggressive child to help prevent injury to either the child or the staff member. An individualized token economy system is used throughout the program. For example, at the secure treatment center there are five levels to be accomplished, however, an individual can jump over a level (s) as long as he/she meets the behavior criteria. Thus it is possible for an individual to "graduate" to a high management group home just two weeks after entering the secure center.

Dr. Taylor noted some observations that have brought about changes in the program design. The staff found out that by-in-large, treatment has not transferred from one place to another in the treatment system. There has been little or no generalization of appropriate behavior to new sites. Now, the clients are never in a situation where they are without staff they know--someone always goes along until a successful transition and behavior generalization has occurred.

Another area that the program was initially unprepared to deal with effectively, was the need for family services. Many of the children had been separated emotionally, if not physically, from their families for years. They found that while in all too many cases the family had given up on the child, the child had not given up on the family. This has necessitated having to work with the child to teach him/her that the family means what it says, as well as working with the family around the kind of statements they are making--why and how to say what they mean. Most of the families have been problematic for some time before being referred to the Wake System. Approximately

75% of the children claim to have been systematically abused from an early age. These claims are not always documented, however.

Financial information was next discussed by Dr. Taylor, It currently costs $780,000 per year to serve sixty clients -- but it is anticipated that the cost may rise to between $15,000 and $20,000 per client per year (or between $900,000 and $1,200,000). This compares favorably with the cost of an adolescent unit in a psychiatric hospital which is $63,000 per year. The initial funding came from Wake County who funded the secure treatment center with money that it had allocated for the detention center. The state DMH put in another $400,000. Dr. Taylor noted that this program is the highest priority human service program in North Carolina, 11 other communities are beginning to adopt the Wake Juvenile System model, however some are trying to do it without a secure facility. There is some doubt, though, as to whether or not this will provide as effective a system of service. The secure facility at Wake County keeps three beds open for crisis cases. It is also anticipated that about 10% of the population will need long term secure treatment. Program officials are not certain that the Secure treatment center should be used for this purpose, since it will tie-up much needed crisis beds. This problem is yet to be resolved.

In answer to a question regarding the legal basis for admission to the program Dr. Taylor explained that there were two legal routes to be followed:

1. Local level--
   (a) Chapter 7A--Secure Custody Order of the Juvenile Court--the judge orders commitment/secures custody of an individual--may also order that an evaluation be done and that results and the strengths/weaknesses be reported back to the court.
   (b) Chapter 122--deals with voluntary admission by parent or guardian. Within 24 hours the child must be seen by a psychiatrist (a qualified examining physician); within 10 days there must be a hearing before a judge, to include a psychologist, childs primary therapist, attorney for the child, parent/guardian; DSS worker, Court Counselor.

2. State level--
   In order to be admitted to a secure facility the individual must be a member of the class. Some non-class beds have been set-aside in the group homes and day treatment/educational settings.

Dr. Taylor stressed, that while he felt a secure facility was a necessary element in the system-- a secure facility should <u>not</u> be the only element--there must be less secure places for individuals to move on to when they are ready.

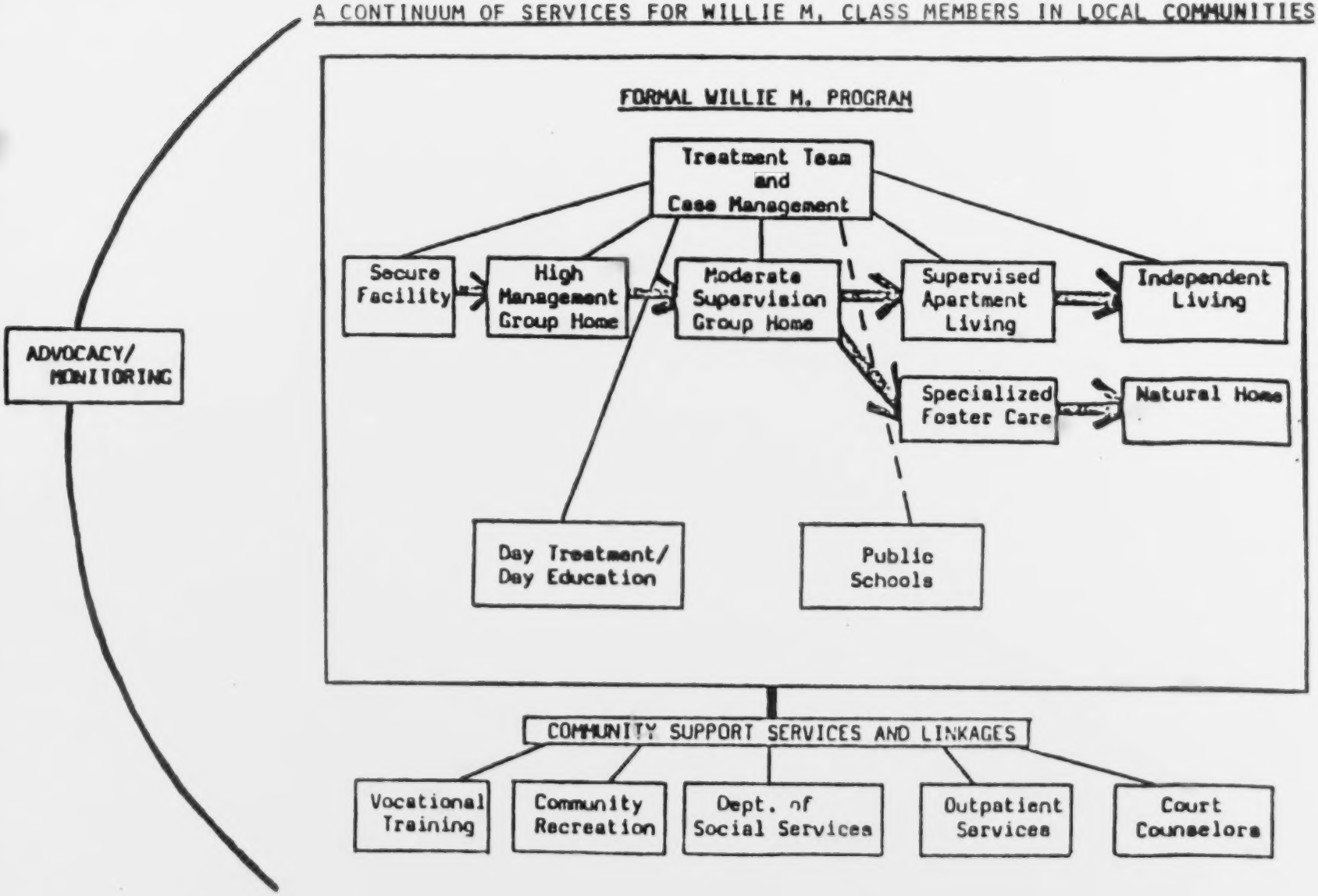
It is interesting to note, that while the local communities are not party to the suit (the State is the Defendant), the state has decided that the local Mental Health Agencies should be the provider of service providing of course, that the local Mental Health Agency is willing to operate such a program. Dr. Taylor reported that most of the counties are agreeing to participate in some way.

While the Wake County Juvenile System primarily serves the residents in Wake County, the secure facility is available to three other counties that, together with Wake, comprise a zone. Any county placing a client in the secure facility must provide a member for that client's treatment team and must plan for the client's return to the home community and participation in that county's programs.

North Carolina, according to Dr. Taylor, implemented a zone configuration to help deal with the rural areas of the state where there is usually a low population base. Within a zone, one county may specialize in one program area, and another county in something else. The plans are for almost every zone to have a secure facility to accomodate fifteen or less persons.

Dr. Taylor concluded his remarks by emphasizing the need to develop programs that can be individualized to meet the individual needs of the clients and still be efficient and cost-effective. He re-emphasized the fact that the dually diagnosed MR/DD person does not have to be locked up in a state institution in order to receive services, but can, with careful planning, be successfully maintained in the community.

A CONTINUUM OF SERVICES FOR WILLIE M. CLASS MEMBERS IN LOCAL COMMUNITIES



Appendix D

DATA ANALYSIS

Mentally Retarded/Emotionally Handicapped Adults

Procedure

A total of 44 cases of MR/EH adults from the 1979-81 case files of SCP&A were assembled for the study. One was discarded due to primary diagnosis of autism. The number and regional districtuion of cases examined in the study are shown below.

Number of MR/EH Adult Cases by Region

Region	Number	Percent
I	5	11.6
II	11	25.6
III	4	9.3
IV	16	37.2
Offender	7	16.3
Total	43	100.0

Tables I, II and III report the demographic characteristics of this adult group: age, race, sex and home county.

One-third of this group were aged 19-21 with (2) 19's, (6) 20, and (6) 21. About half were in the 20-29 age group, 14 percent in their 30's and about 5 percent in their 40's. None were older than 45.

Table I
Age Distribution of MR/EH Adults

Region	I	II	III	IV	OA	Total	Percent
Age Range							
19-21	1	4	2	3	4	14	32.6
22-29	3	5	1	10	2	21	48.8
30-39	0	2	1	3	0	6	13.9
40-49	1	0	0	0	1	2	4.7
50-59	0	0	0	0	0	0	0
60+	0	0	0	0	0	0	0
Total	5	11	4	16	7	43	100.0

Table II shows the race and sex distribution of these cases. The group was 72% male and 28% female; this distribution was similar for both racial groups. The group of cases was 56% white and 44% black, again with the distribution being similar for the male and female populations. The percentage of the cases that are black is somewhat higher than their representation in the general South Carolina population.

Table II
Race and Sex Distribution of MR/EH Cases

SEX	M	%	F	%		
RACE					Race Total	Race Percent
B	14 (73.7)	45.2	5 (26.3)	41.7	19	44.2
W	17 (70.8)	54.8	7 (29.1)	58.3	24	55.8
Sex Total	31		12		43	100.0
Sex Percent	72.1		27.9		100.0	

Table III shows the South Carolina counties represented as home counties of the cases in the study. Seventeen of the 46 South Carolina counties were represented in the group; 30% of the cases were from Charleston county. The tendency toward out-of-county placement for this group was apparent when home county was compared to current county of residence. About half of the group was currently residing out of their home county; 42% were located in Richland county. The distribution reflects the location of state mental health, mental retardation institutions and correctional facilities. None were placed out-of-state. Most individuals were residing in the region of their home county, however. Only 12 (28%) were currently residing out of their home region.

Table III
Origin and Current Location of MR/EH Cases By County

	Home County		County of Current Residence	
	Number	Percent	Number	Percent
Beaufort	1	2.3	1	2.3
Berkeley	3	7.0	1	2.3
Charleston	13	30.2	6	14.0
Chesterfield	1	2.3	0	0
Dorchester	3	7.0	6	14.0
Florence	3	7.0	1	2.3
Georgetown	2	4.6	2	4.6
Greenville	2	4.6	1	2.3
Hampton	1	2.3	1	2.3
Horry	2	4.6	1	2.3
Jasper	1	2.3	0	0
Kershaw	1	2.3	0	0
Laurens	0	0	2	4.6
Lexington	1	2.3	0	0
Newberry	2	4.6	1	2.3
Richland	3	7.0	18	41.9
Spartanburg	2	4.6	1	2.3
York	2	4.6	1	2.3
	43		43	

Current County of Residence

Same as Home County	22	51.2%
Out of County Placement	21	48.8%
Out of Region Placement	12	27.9%
Out of State Placement	0	0%

Table IV reports the level of mental retardation and other handicaps evidence by this case group by region.

About 85% of adults in these cases were classified as mildly or moderately retarded, evenly distributed between these two levels. Nine percent were severely retarded and in 3 cases the MR level was unspecified. Twenty-three cases (54%) had at least one other handicap in addition to retardation and emotional disorders, with epilepsy (19%) and speech handicaps (16.3%) being the most prevalent. Clearly this is a multi-handicapped group.

Table IV
Level of MR and Other Handicaps

Region	I	II	III	IV	OA	Total	Percent
Mental Retardation							
Level: Mild	1	6	1	7	3	18	41.9
Moderate	2	5	1	8	2	18	41.9
Severe	2	0	1	1	0	4	9.3
Profound	0	0	0	0	0	0	0
Unspecified	0	0	1	0	2	3	6.9
Number with OTHER Handicaps	4/5	6/11	2/4	6/16	5/7	23/43	53.5
Speech	2	0	1	3	1	7	16.3
Hearing	1	1	0	0	0	2	4.6
Motor	1	0	0	0	0	1	2.3
Visual	0	1	0	3	0	4	9.3
Epilepsy	0	3	1	2	2	8	18.6
Severe Scoliosis	0	1	0	0	0	1	2.3
Brain damage	0	0	0	0	2	2	4.6
Hypoglycemic	0	0	0	0	1	1	2.3

The date of first diagnosis of emotional handicap and the source of that diagnosis was collected in order to ascertain whether the problems had been long-term or was a recent occurrence. Table V reports these results. Unfortunately in over half of the cases, SCP&A case records did not contain this information. For the cases that did, however, over three-fourths had been diagnosed during their school years, and for about half of those cases diagnosis was by school personnel. In only three cases was the EH diagnosis reported to be by DMH personnel.

Table V
First EH Diagnosis and Source of Diagnosis

First Diagnosis	Number	Percent
Grade School/Teen years	15	34.9
Recent-adult years	4	9.3
Unknown	24	55.8
Source		
School	8	18.6
DMR	7	16.3
DMH	3	7.0
M.D.	2	4.6
DYS	1	2.3
Unknown	22	51.2

Other Characteristics

History of dangerous behavior was whether the adult was at risk for criminal placement were judgments made by the case examiner based on case record descriptions of EH behavior problems with the advocate responsible for the case and record of court involvement in the case. Tables VI, VII and VIII report these results.

Dangerous behavior was classified according to whether it was dangerous to self, to others or to property. Behavioral histories were examined and categorized. Table VI reports case categories results according to whether behavior was violent, destructive to property or both violent and destructive. Nine cases, about 22%, were considered not dangerous. About 30% were violent only and 5% destructive to property only. Eighteen cases (43%) had histories of both violent and destructive behaviors. Nearly 80% of these adults had histories of dangerous behavior.

Judgment on risk for correctional placement was made on 31 of the 43 cases (72%). Of these cases 58% were considered at risk, primarily due to dangerous assaultive behavior for which criminal charges could be or had been brought. (See Table VII).

Information on court involvement was incomplete for Region IV and was reported for 22 of the 43 cases (51%). Of those cases reported, 64% had at least one instance of court proceedings. Probate Court involvement was primarily for purposes of committment. Criminal Court charges included both criminal personal and property offenses. Five individuals in the Offender group had histories of numerous court proceedings. Four of the Region II cases had criminal charges pending.

Table VI
History of Dangerous Behavior

Region	I	II	III	IV	OA	Total Violent	Known Cases Percent
VIOLENT							
Self only	1			2		3	
(abuse/suicide attempts)						13	
Self & Others		3	1	1	3	8	30.9
Others only				2		2	
						Total Destructive	
DESTRUCTIVE TO PROPERTY		1			1	2	4.8
						Total Violent & Destructive	
VIOLENT AND DESTRUCTIVE							
Others & Property	2	1		2	1	6	
Self & Property						18	42.9
All SOP	1	6	2	1	2	12	
						n=33	
NOT DANGEROUS	1	0	1	7	0	9	21.4
UNKNOWN	0	0	0	1	0	1	
Total	5	11	4	16	7	43	

Table VII
At Risk For Correctional Placement

Region	I	II	III	IV	OA	Total	Percent (known)
YES	1	7	1	3	6	18	41.9 (58.0)
NO	4	4	0	4	1	13	30.2 (41.9)
Not Reported	0	0	3	9	0	12	27.9

Table VIII
Court Involvement In Case

Region	I	II	III	IV	OA	Total	Percent of Known Cases
YES	2*	5**	0	0	7***	14	63.6%
NO	3	1	4	0	0	8	36.4%
Not Reported	0	5	0	16	0	21	48.8%

* 2 probate, 2 family
** 2 probate, 4 criminal
*** 5 probate, 8 family, 8 criminal

Abuse History

Table IX reports the frequency of cases having a history of abuse as a child or teen. One third of the cases for which this information was known had abuse history. On only 9 of the cases (20%) was this data reported, however.

Table IX
History of Abuse

Region	I	II	III	IV	OA	Total	Percent (known)
YES	1	0	1	0	1	3	7.0 (33.3)
NO	4	0	2	0	0	6	13.9 (66.7)
Not Reported	0	11	1	16	6	34	79.1

Are These Adults Being Appropriately Served?

A major objective of this case documentation was to determine whether these mentally retarded/emotionally disturbed adults were obtaining services appropriate for their handicap. Table X reports by region the results of this judgment made by the case examiner following review of the SCP&A case records and interviews with advocates responsible for each case. Cases for which appropriate services were recommended but delivery was uncertain, or in which service appropriateness is questionable were recorded as NO.

Table X
Receiving Appropriate Services

Region	I	II	III	IV	OA	Total	Percent
YES	3	5	2	9	4	23	53.5
NO	2	6	2	7	3	20	46.5

In slightly over half of the cases examined (53%), the client was judged to be receiving services appropriate for his/her condition. In twenty cases, (46%), however, one or more of the service recommendations or needs of the client were not being implemented. Table XI reports the type of services needed or recommended for these clients.

The unserved client group presents the following demographic characteristics:

Male	16	80%	Black	9	45%
Female	4	20%	White	11	55%

On both of these dimensions, this group is fairly similar to the total group of cases.

History of Dangerous Behavior

Unserved			Served	
YES	16	84%	17	74%
NO	3	16%	6	26%
UNKNOWN	1		0	

In terms of dangerous behavior history, this group is also fairly similar, though slightly more likely to include dangerous clients. Mild and moderate levels of retardation are evenly distributed in the group, and 7 (35%) have handicaps in addition to the MR/EH conditions.

Eighty percent of this group have been rather extensive recipients of both mental health and mental retardation services, both on an in-patient and outpatient basis. One major difficulty, however, seems to be that clients in custody of DMH lack MR services and vice versa.

Table XI

Service Needs	Number	Total Number	Percent
in custody DMH - need MRtx	3	7	35%
in custody DMR - need MHtx	4		
DMR reject - need Res. MHtx	1	1	5%
needs MR/MHtx	2	2	10%
needs LRE	1	1	5%
refused services school (2); VR (4)	6	7	35%
refused services MH	1		
needs VR, ADA, LT - status unknown	1		5%

A second and probably more serious dilemma is that of service refusal. Seven cases, 35%, refused SCP&A assistance in obtaining services or refused to keep appointments or participate in services recommended or arranged for them. It is understandable that the 17-21 year old individual may feel demeaned and out-of-place in a school program; refusal of VR services is less understandable and perhaps deserves further examination of VR's capability to deal with the MR/EH individual.

Appendix E

THE ROCK CREEK FOUNDATION

8435 GEORGIA AVENUE

SILVER SPRING, MD. 20910

The Rock Creek Foundation is a private community-based program that is nationally recognized for its innovative treatment programs for persons who are both emotionally disturbed and mentally retarded.

ROCK CREEK'S PROGRAM SERVICES

All services are designed to address the needs of young adults who are developmentally disabled and emotionally handicapped.

PSYCHIATRIC DAY TREATMENT
(8:30 - 4:30)

Provides comprehensive services for individuals who are both developmentally disabled and simultaneously experiencing emotional/behavioral difficulties. Individual, group and family therapy are integrated with ongoing life skills instruction, community excursions and vocational evaluation, including transitional employment and competitive placement and follow up.

Contact: Ellen Fabian, M.A. Program Services Coordinator

Funding: Services reimbursable by major health insurance plans. (Blue Cross and Blue Shield, Champus, etc., limited funding slots are also available)

PSYCHO-SOCIAL CLUB HOUSE (Cornerstone)
(8:30 - 3:00)

Provides psychosocial rehabilitation services emphasizing acquisition of vocational and interpersonal skills in a peer regulated and run setting. Evaluation, counseling, transitional and competitive employment is available. Program is designed to assist individuals with vocational/life skills deficits who may be experiencing mild or minor emotional difficulties. Therapy is available through other agency programs.

Contact: Ellen Fabian, M.A. Program Services Coordinator

Funding: Limited funding slots are available, out of pocket payments.

OUT PATIENT PSYCHIATIC SERVICES

Individual, group and family therapy is available as well as psychological/psychiatric evaluation (by appointment only).

Contact: Ellen Fabian, M.A. Program Services Coordinator

Funding: Health Insurance; limited funding slots are also available.

COMMUNITY VOCATIONAL SERVICES

Services on an as needed basis. Assessment, evaluation, counseling, transitional employment, competitive placement and follow-up.

Contact: David Wachter, Vocational Services Coordinator

Funding: Division of Vocational Rehabilitation; out of pocket.

COMMUNITY SOCIALIZATION SERVICES

Individual life skills instruction available. Weekend Social programming (advanced and intermediate).

Contact: Ron Ward, Director of Socialization

Funding: Division of Vocational Rehabilitation; out of pocket.

Clients can either participate in a full-time (8:30 - 4:30) program or can have individualized programs drawing from a variety of service areas.

All clients and their families involved in Rock Creek Foundation's service system have access to our 24 hour crisis service.

RESIDENTIAL SERVICES

Services provided for clients participating in one of the Day Programs on a priority and as needed basis. Houses structured from highly supervised group homes to satellite apartments.